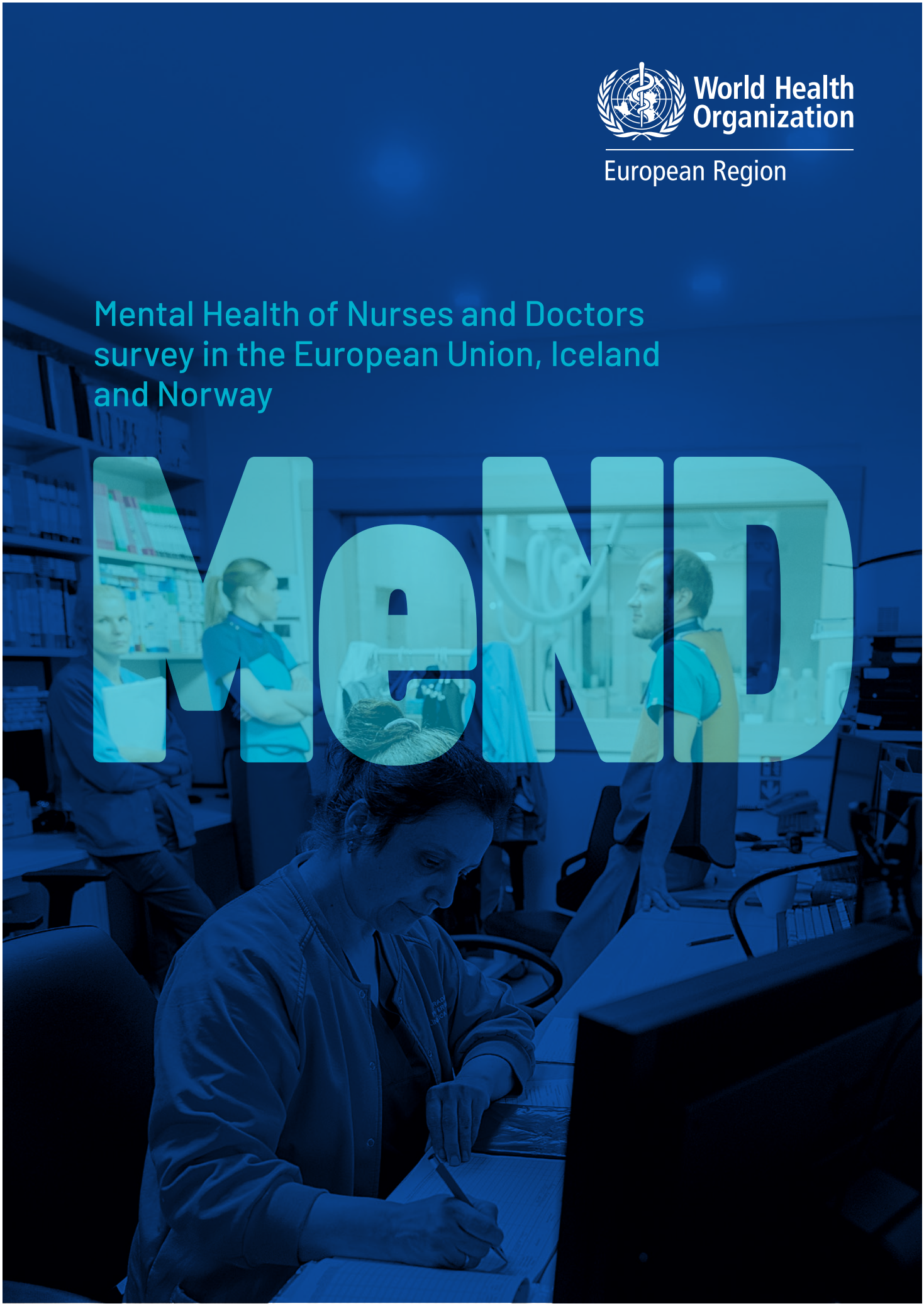
World Health Organization

European Region

Mental Health of Nurses and Doctors survey in the European Union, Iceland and Norway

MeND



Abstract

The Mental Health or Nurses and Doctors (MeND) survey, conducted by WHO Regional Office for Europe under a contribution agreement with the European Commission, aimed to explore the mental health, well-being and working conditions of doctors and nurses in the 27 European Union countries plus Iceland and Norway. The survey was disseminated from October 2024 to April 2025 across all 29 countries, obtaining 122 048 responses, of which 90 171 were valid. The findings indicated a high prevalence of mental health conditions and unsafe working conditions – including violence, extended working hours and shift work – across all studied countries. Unsafe working conditions were associated with poorer mental health; conversely, the presence of workplace supports and protective factors was associated with better mental health. Seven policy actions are listed to support Member States in prioritizing action to improve working conditions and monitor progress.

Keywords

MENTAL HEALTH, HEALTH WORKFORCE, CROSS-SECTIONAL SURVEY, WORKING CONDITIONS, ANXIETY, DEPRESSION, WORKPLACE VIOLENCE

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Foreword

Protecting the mental health of our health workforce is not only an act of compassion – it is a strategic investment in the health and well-being of our population. Health systems cannot function without health workers, who are the pulse that keeps these systems alive.

Day after day, doctors and nurses show tireless commitment and unwavering compassion. Yet this dedication comes with heavy costs. One in four work more than 50 hours per week giving rise to imbalance between their work and professional lives. One in three have experienced violence at work, undermining their sense of safety and their ability to do their jobs effectively.

These working conditions are taking a toll on workers' mental health. Our survey indicates that one in three doctors and nurses report symptoms of anxiety and/or depression. A staggering one in ten report that they think about ending their life or harming themselves.

This report adds critically important detail leading to a better understanding of the alarm we signalled already in 2022, when our ***Health and care workforce in Europe: time to act report*** called the health and care workforce shortage a "ticking time bomb" for the WHO European Region. The mental health challenges experienced by doctors and nurses were highlighted as a factor contributing to this shortage, but we did not yet have the necessary data and evidence to pinpoint the priorities for action. Now, based on responses of over 100 000 nurses and doctors from 29 countries – making this the largest survey of its kind ever conducted in Europe – this report shows with unprecedented clarity, key priority areas to successfully address this crisis.

When health and care workers have good mental health and well-being, they can provide safer, more effective care. They can better harness the benefits of innovation, and they can continue to build and instil the trust and confidence of the communities they serve. Creating better working conditions that enable this is the shared responsibility of policymakers, healthcare leaders, and stakeholders at every level of the system. This means tackling excessive working hours and shift burdens. It means zero tolerance for bullying, violence and harassment. It means ensuring every doctor and nurse can access the mental health support they need, free from stigma. It means building the capacity of leaders and managers to recognize when staff are struggling and to respond with compassion, while also improving day-to-day working conditions.

WHO Regional Office for Europe is already supporting countries in these areas through our European Frameworks for Action on Mental (2021–2025) and Health and Care Workforce (2023–2030). This survey marks only the beginning. We are expanding it to more countries, encouraging Member States to use it to monitor the mental health and working conditions of their health workers. This work is at the heart of our partnership with the European Commission, "Addressing mental health challenges in the EU, Iceland and Norway," as is protecting the mental health of those who care for us. Their well-being and that of all current and future patients depend on what we do next.

Dr Hans Henri P. Kluge
Regional Director
WHO Regional Office for Europe

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Abbreviations

CAGE questionnaire	C-cut down, A-annoyed, G-guilty and E-eye-opener questionnaire
COPSOQ	Copenhagen Psychosocial Questionnaire
COVID-19	coronavirus disease
EU	European Union
EWCTS 2021	European Working Conditions Telephone Survey 2021
GAD-7	7-item Generalized Anxiety Disorder questionnaire
HCW	healthcare worker
MeND	Mental health of Nurses and Doctors
OECD	Organisation for Economic Co-operation and Development
PHQ-9	9-item Patient Health Questionnaire
WHO-5	World Health Organization-Five Well-Being Index

Glossary

- **Depression:** This term is used to report on the outcome of probable major depressive disorder, as measured by a score of 8 to 12 on the 9-item Patient Health Questionnaire (PHQ-9), depending on the country.
- **Anxiety:** This term is used to report on the outcome of probable generalised anxiety disorder, as measured by a score of 5 to 12 on the 7-item Generalised Anxiety Disorder questionnaire (GAD-7), depending on the country.
- **Suicidal thoughts:** This term is used to report on the presence of thoughts that one would be better off dead or of wanting to harm oneself, as measured by a positive score to the ninth item of the PHQ-9.
- **Alcohol dependence:** This term is used to report on the outcome of probable alcohol dependence, as measured by a score of 2 points or higher on the CAGE ("Cut down, Annoyed, Guilty, and Eye-opener") questionnaire.
- **Well-being:** This term is used to report on the outcome of mental or emotional well-being, as measured using the World Health Organization-Five Well-Being Index (WHO-5). It encompasses experience of positive moods, calm and vitality. It is rated on a percentage scale from 0 to 100, with scores below 50 indicating a poor level of well-being.
- **Mental health conditions:** This term is used to report on the collective mental health outcomes measured in the survey (ie depression, anxiety, suicidal thoughts and alcohol dependence.
- **Mental health**: This term describes a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community.

Executive summary

Europe is facing a worsening health workforce crisis *(1)*. The growing number of practicing doctors and nurses is not keeping pace with rising healthcare demands *(2)*. Among the factors contributing to this gap are strenuous working conditions and poor mental health among health and care workers, which are pushing some to leave the profession altogether. Protecting and retaining a resilient workforce is essential for health systems to deliver high-quality care to those in need *(3,4)*.

To obtain a clearer picture of the mental health, well-being and working conditions of doctors and nurses, the WHO Regional Office for Europe launched the Mental health of Nurses and Doctors (MeND) survey in October 2024, under its collaboration agreement with the European Commission, "Addressing mental health challenges in the European Union, Iceland and Norway".

The survey – the largest of its kind to date – was disseminated between October 2024 and April 2025 across the European Union, Iceland and Norway, supported by a network of six European medical and nursing associations and their national members. Over 120 000 doctors and nurses across 29 countries responded, with 90 171 valid responses included in the final analysis.

This report synthesizes the data collected using the MeND survey to understand how doctors and nurses are faring in their mental health and well-being, and what factors in their workplaces may be helping or harming them.

The findings are sobering.

Mental health difficulties are widespread among doctors and nurses

- One in three doctors and nurses report symptoms of depression or anxiety.
- Three per cent report signs of probable alcohol dependence.
- The prevalence of anxiety and depression varies markedly across countries, with depression prevalence ranging from 15% to 50% of workers surveyed.
- Doctors and nurses are five times as likely as the general population to experience symptoms of depression (32% vs 6%) *(5)*.
- Over 10% of doctors and nurses report thoughts of ending their life or harming themselves.

Exposure to harmful working conditions is highly prevalent and detrimental to mental health

- One in three doctors and nurses were exposed to bullying or violent threats at work in the past year, while 10% report exposure to physical violence and sexual harassment.
- One in four doctors works over 50 hours per week.
- Workers exposed to violence, harassment and bullying report up to double the prevalence of mental health difficulties.
- As working hours and frequency of night shifts increase, so does the risk of experiencing mental health difficulties.

Workplace protective factors are strongly associated with lower depression and anxiety

- Mental health difficulties are half as prevalent among doctors and nurses with frequent social support from colleagues and supervisors (17% vs 51% in those with no social support).
- Greater influence over work and better work–life balance are both associated with a much lower prevalence of depression and anxiety.
- Workplace support structures, especially those related to violence prevention, are linked a 50% lower prevalence of mental health difficulties.

Mental health difficulties in doctors and nurses can negatively impact the delivery of healthcare services – reporting depression was associated with taking more sick leave and a greater intention to leave their job.

Based on these findings, and in line with prevailing frameworks and guidelines[1], this report proposes a series of policy actions (Table ES.1) to prevent mental ill health, protect and promote mental health and well-being and create the enabling environments necessary to reverse the worsening crisis facing health care systems.

Table ES.1. List of policy actions

1 **Enforce a zero-tolerance approach to bullying, harassment and other forms of workplace violence**	**Improve predictability and flexibility around shift work to protect mental health and provide workers with greater control over scheduling** 2
3 **Manage overtime in line with health workers needs and entitlements, while reimagining workplace norms and culture**	**Manage excessive workload to deliver quality health services, by focusing on improving staffing approaches and optimizing workflows** 4
5 **Build the capacity of healthcare leaders and managers to promote and protect staff mental health and well-being**	**Make mental health and substance use support available and accessible to all workers and facilitate early intervention** 6
7 **Prioritize regular monitoring and reporting of mental health and working conditions**	

Protecting the mental health of our health and care workers is not just the right thing to do – it is essential for the future of health care in Europe.

1 Including the European Framework for Action on Mental Health 2021–2025 *(6)*, the European Framework for Action on Health and Care Workforce 2023-2030 *(7)*, WHO guidelines on mental health at work *(8)*, the WHO Duty of Care Report *(9)*, and the UN Employment Conditions Framework *(10)*,

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2 All references were accessed on 7 October 2025

Introduction

Europe is facing a health and care workforce crisis

In the past five years, Europe has faced natural disasters, global pandemics and wars. These events have directly impacted people's health and well-being, either through their immediate effects on affected communities or knock-on effects through global economic crises. To protect the health and well-being of their citizens, European countries require robust healthcare systems – which in turn require a sufficient and healthy workforce.

However, countries are currently struggling to retain health and care workers and recruit new ones to meet the demand. Should current trends persist, the projected shortage of health and care workers in the European Union (EU) will be 940 000 by 2030[1]. This crisis has many causes *(1)*. The healthcare workforce is ageing: in 2020, nearly 30% of doctors and 18% of nurses were over the age of 55 *(2)*, while the median retirement age is 64.4 years in Organisation for Economic Co-operation and Development (OECD) countries *(3)*. The coronavirus disease (COVID-19) pandemic also played a role, resulting in more than 50 000 health and care worker deaths by 2021 *(4)* and a 62% increase in absenteeism; at one point during the pandemic, 90% of nurses reporting considering leaving their jobs *(5)*. Many health and care workers have also migrated outside the EU to countries such as Switzerland and the United Kingdom, further decreasing availability in their countries of origin *(5)*.

A critical factor considered to be perpetuating the crisis is the mental health and well-being of the health and care workforce. Prior to the COVID-19 pandemic, the mental health of doctors and nurses received little attention *(6)*. Although thousands of surveys have been conducted since 2022 in COVID-19 hotspots worldwide, many were conducted in single settings with small sample sizes, making it difficult to understand the scale of the problem or to make meaningful cross-country comparisons. Regardless, the results are concerning: one third of the health and care workforce report symptoms consistent with depression or anxiety disorders *(7)*. These symptoms are in turn associated with turnover intentions and absenteeism *(8,9)*, creating a vicious cycle. Such mental health difficulties, including suicide, disproportionately affect female health and care workers *(10)*.

The WHO Regional Office for Europe has used a variety of approaches to support Member States in understanding and addressing this crisis in recent years. Mental health was selected as a priority under the European Programme of Work 2021–2025, developed in consultation with European Region Member States, the European Commission and other non-State actors *(11)*. Specific objectives of pressing concern for Member States were laid out in the WHO European Framework for Action on Mental Health 2021–2025 *(12)*, among which was optimizing workplaces as settings for mental health promotion and protection through action at the individual and organizational levels.

The landmark 2022 WHO Regional Office for Europe report *Time to act: the health and care workforce (1)* revealed the ticking time bomb of the health and care workforce shortage in the WHO European Region. This report highlighted the impact of increasing workloads, stress and fatigue on health and care workers' mental and physical health, and the knock-on effects this has on recruitment and retention. To address this crisis, in 2023 all 53 Member States of the WHO European Region unanimously adopted the "Framework for Action on the Health and Care Workforce 2023–2030" *(13)* that included five pillars (retain, optimize, build supply, plan and invest) to improve the health and care workforce in Europe. The central pillar was to retain the health and care workforce through key strategies, including greater protection of the health and mental well-being of health and care workers and the creation of working conditions that enable a healthy work–life balance.

In 2023, the European Commission initiated a comprehensive programme of work to strengthen action on mental health across the EU, including integrating mental health into all relevant EU policies and maximizing the value of these policies at national and local levels. This initiative included entering into a collaboration agreement with the WHO Regional Office for Europe aimed at building mental health policy and systems

1 WHO Regional Office for Europe, unpublished data.

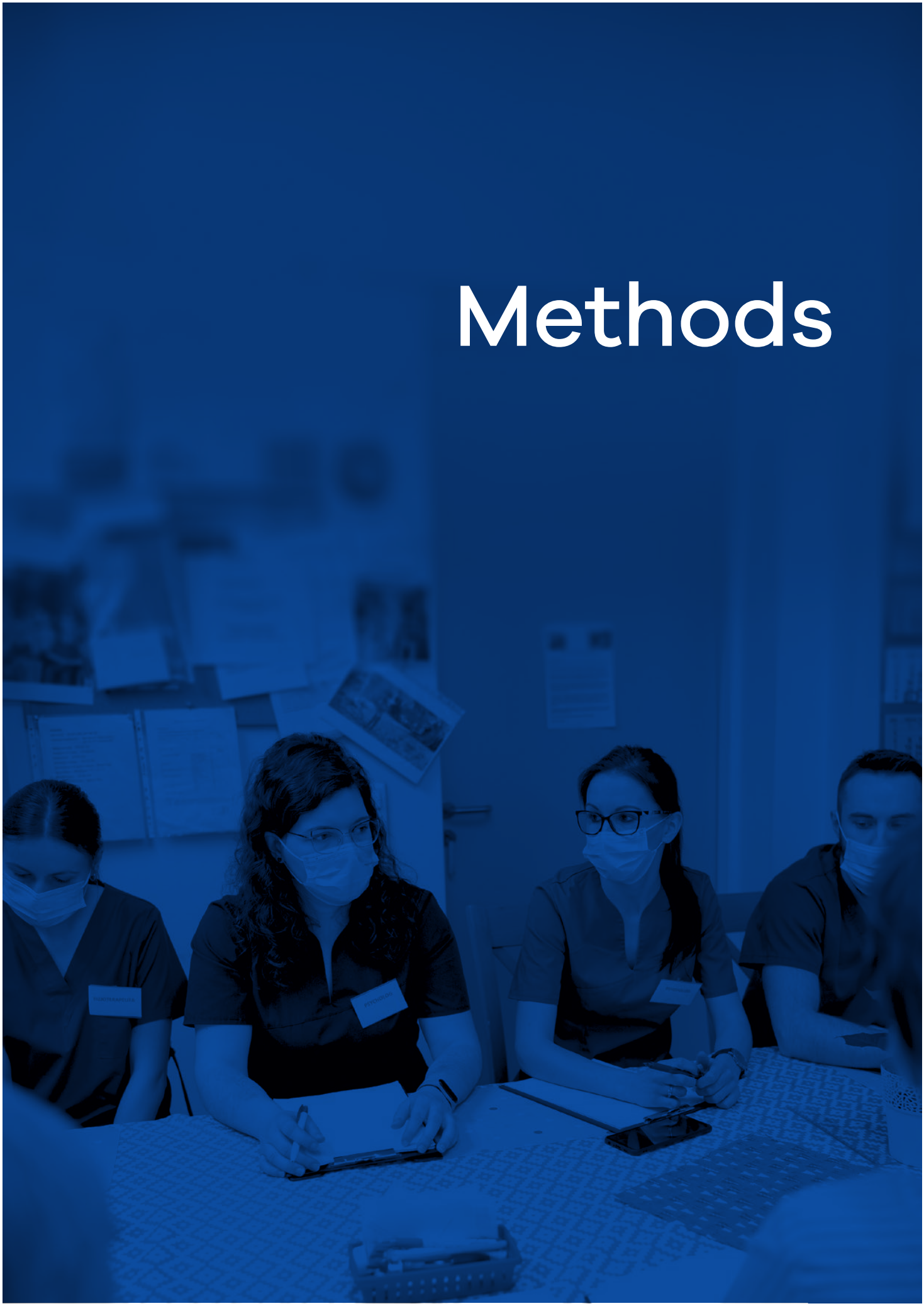
capacity across the Region ("Addressing mental health challenges in the EU, Iceland and Norway"). Protecting and promoting the mental health and well-being of health and care workers is a key output of this agreement.

As part of the "Addressing mental health challenges in the EU, Iceland and Norway" project, the WHO Regional Office for Europe launched the Mental health and in Nurses and Doctors (MeND) survey in October 2024 to gain a fuller picture of the mental health, well-being and working conditions of doctors and nurses in the EU, Iceland and Norway.

The MeND survey – the largest of its kind – ran until April 2025, supported by a dissemination network of six European medical and nursing associations and their national members. Responses were submitted by 122 048 doctors and nurses across the 29 countries, and 90 171 valid responses were included in the final analysis.

This report draws on data collected through the MeND survey to measure the mental health and well-being of doctors and nurses in the EU, Iceland and Norway, as well as the main workplace factors helping and harming them. From these results, six policy actions are proposed to inspire national and regional initiatives to protect and promote mental health. This report is intended to serve as a baseline for measuring progress in policy action going forward.

Methods



The MeND survey is a large cross-sectional survey of doctors and nurses conducted in the 27 countries of the European Union, Iceland and Norway. It examines the mental health and well-being of doctors and nurses (outcomes) and how these are associated with select working conditions (exposures) across different countries. The instrument consists of 76 items covering sociodemographic characteristics, workplace factors and mental health outcomes. Most items were drawn from validated questionnaires or were developed ad hoc to address specific research questions. The survey instrument was developed in English and translated into the 25 languages of the participating countries.

Data collection took place between 23 October 2024 and 10 April 2025. Until 28 February 2025, participants were recruited primarily through national professional associations affiliated with six European medical and nursing associations: European Junior Doctors Association, Standing Committee of European Doctors, European Union of General Practitioners, European Union of Medical Specialists, European Federation of Nurses Associations and European Forum of National Nursing and Midwifery Associations. From 1 March onward, the survey was also disseminated via social media channels. For details on the survey instrument, recruitment methodology and dissemination, see Annex 1.

Four mental health outcomes were measured:

- depression: probable major depressive disorder, as measured by a score of 8 to 12 on the 9-item Patient Health Questionnaire (PHQ-9), depending on the country;
- anxiety: probable generalized anxiety disorder, as measured by a score of 5 to 12 on the 7-item Generalized Anxiety Disorder questionnaire (GAD-7), depending on the country;
- suicidal thoughts, as measured by a positive score on the ninth item of the PHQ-9; and
- alcohol dependence: probable alcohol dependence, as measured by a score of 2 points or higher on the CAGE questionnaire [C – cut down, A - annoyed, G – guilty and E – eye-opener].

Two types of statistical analyses were conducted for each main objective. To describe the sample characteristics, frequencies, percentages, medians, means and their associated dispersion statistics are provided where appropriate. Sum and dichotomous scores were computed for the PHQ-9, GAD-7 and CAGE scales, using cut-offs validated across countries. To estimate the associations between workplace exposures and mental health outcomes, logistic multilevel regression models were used, adjusted for age, gender, profession and country.

All analyses were conducted using complete case data. We did not apply imputation methods, based on the assumption that missingness was largely at random. R and R Studio were used for data cleaning and analysis.

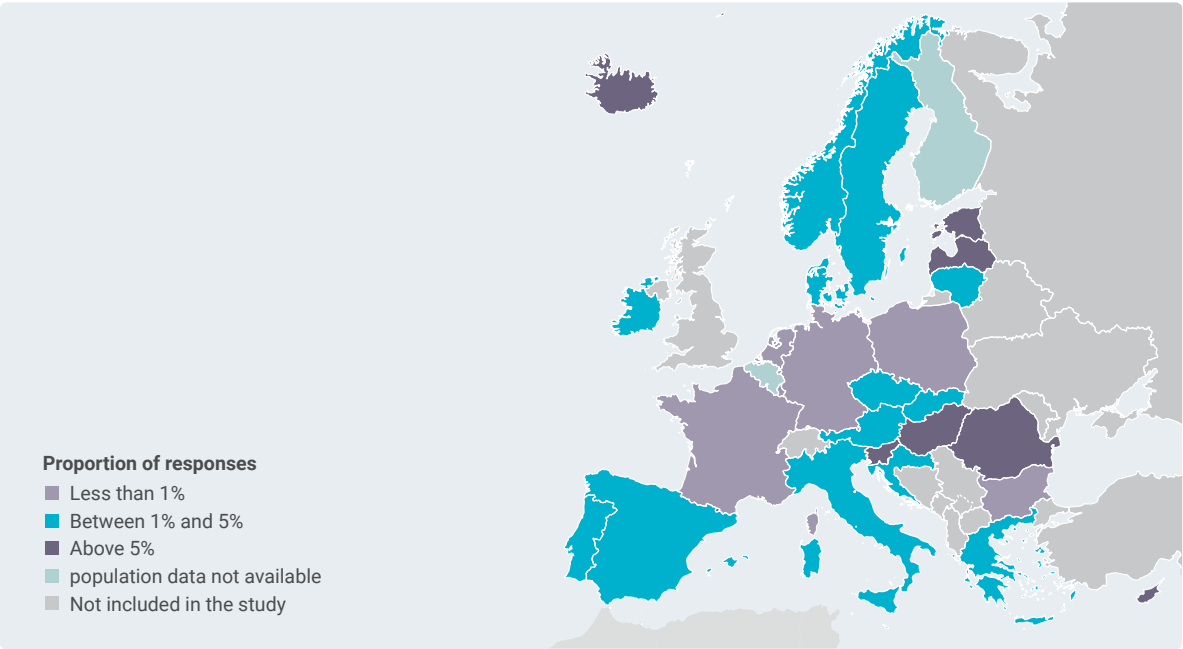
Findings

Number of responses and sample characteristics

Over 100 000 doctors and nurses in the EU, Iceland and Norway responded to the survey

Responses to the MeND survey were submitted by 122 048 doctors and nurses. Of the 90 171 valid responses, 37 864 were from doctors and 52 307 were from nurses. The combined proportion of responses from doctors and nurses was over 1% of the total population of these professionals, making it the largest survey of its kind ever conducted.[2] The highest proportion of responses was obtained in Hungary, Iceland and Latvia, while the lowest proportions were recorded in France, Germany and Netherlands (Kingdom of the) (Fig. 1).

Figure 1. Proportion of responses across countries

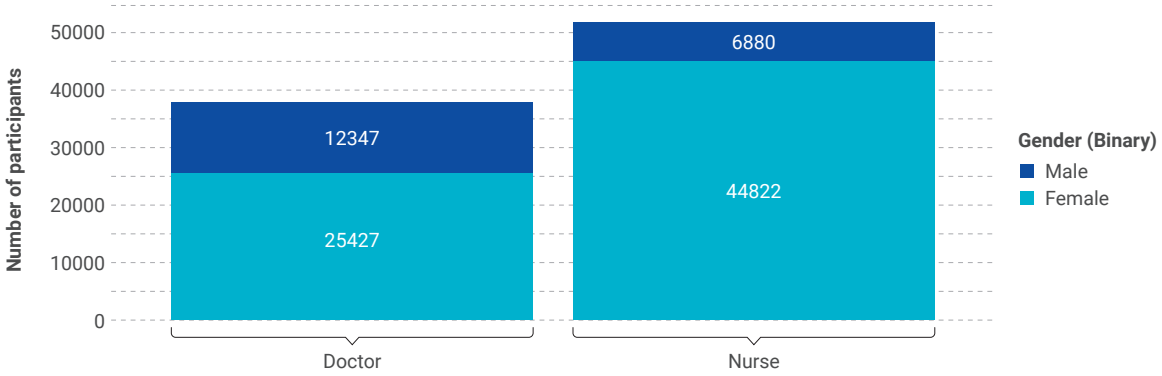


Note: Proportion calculated based on the total number of doctors and nurses reported by each country as part of the WHO National Health Workforce Accounts tool. Data for Belgium and Finland were not available.

2 Proportions of responses are estimated based on the total number of doctors and nurses reported by each country as part of the WHO Regional Office for Europe, OECD and Eurostat joint questionnaire on non-monetary healthcare statistics. For more information, see Annex 1: Methodology.

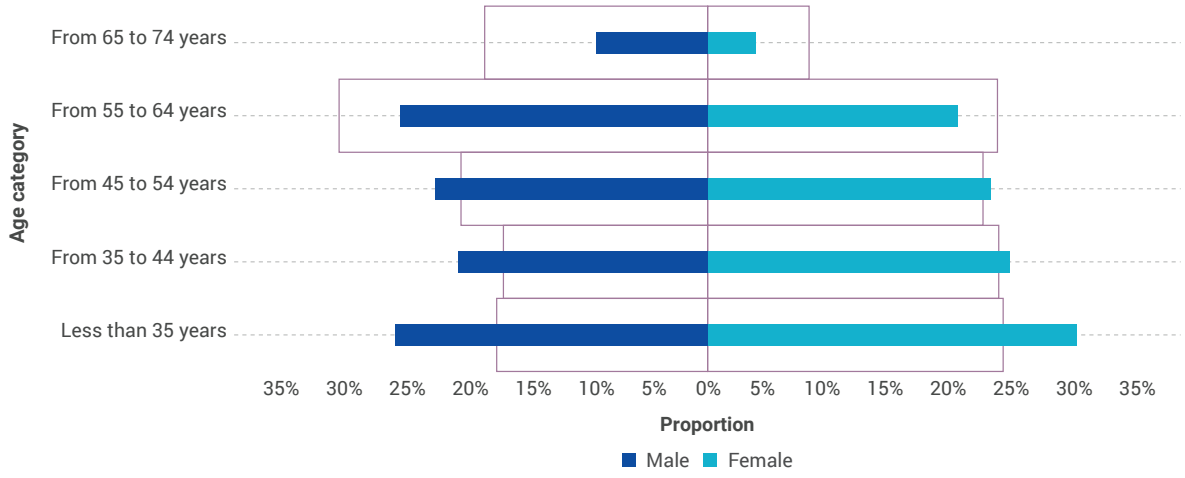
The total number of responses was higher among nurses and women. These findings are consistent with the proportion of women in the healthcare workforce *(14,15)*, and with participation rates in health surveys. The number of responses by profession and gender is presented in Fig. 2. There was a very small proportion of gender-diverse responses.[3] Most respondents were between 41 and 60 years old, married and had children. For more details of the sample, see Annex 1: Methodology.

Figure 2. Number of responses, by profession and gender



The age and gender distribution of respondents in the sample closely resembles the overall health workforce population (Fig. 3 and 4). The largest discrepancies appear among female doctors and nurses under the age of 35.

Figure 3. Difference between sample and population distributions of doctors, by age group and gender

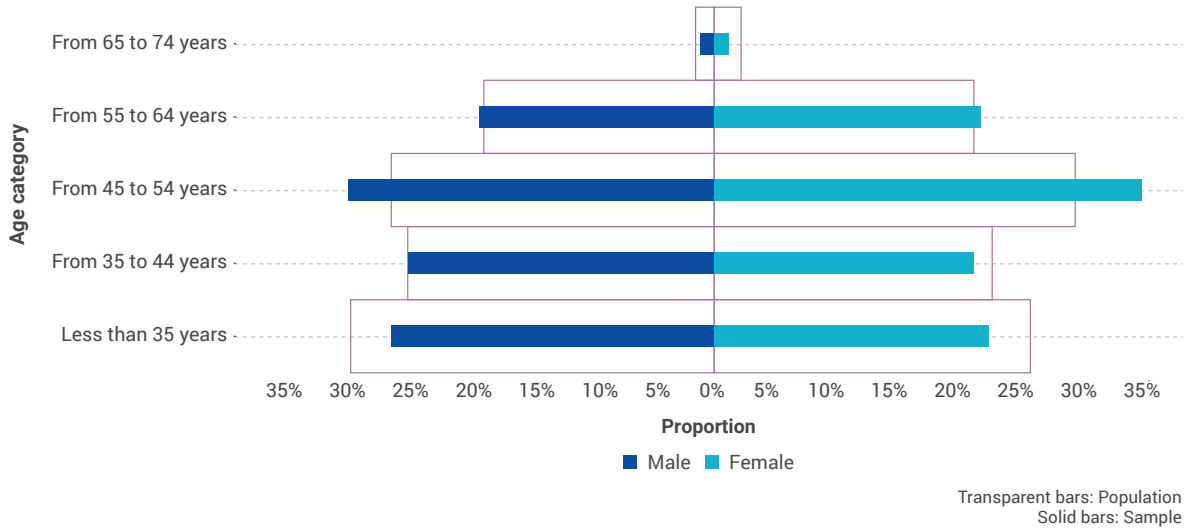

Age category
From 65 to 74 years
From 55 to 64 years
From 45 to 54 years
From 35 to 44 years
Less than 35 years
35% 30% 25% 20% 15% 10% 5% 0% 5% 10% 15% 20% 25% 30% 35%
Proportion
Male
Female

Transparent bars: Population
Solid bars: Sample

Note: Population distribution data are drawn from the WHO Regional Office for Europe, OECD and Eurostat joint questionnaire on non-monetary healthcare statistics (data not available for some countries and age groups). Transparent bars indicate population distribution; solid bars represent the survey's sample distribution.

3 Participants who identified as gender-diverse had the option to specify their gender after selecting "other". However, only 107 people (less than 0.01% of the total sample) identified as gender-diverse. Because of this small number – and their uneven distribution across countries, professions and age groups – it was not possible to include this group in the statistical models or comparative analyses. Although mental health and well-being outcomes within this subgroup are reported, these figures should be interpreted with caution.

Figure 4. Difference between sample and population distributions of nurses, by age group and gender


From 65 to 74 years
From 55 to 64 years
From 45 to 54 years
From 35 to 44 years
Less than 35 years
Age category
35% 30% 25% 20% 15% 10% 5% 0% 5% 10% 15% 20% 25% 30% 35%
Proportion
Male
Female
Transparent bars: Population
Solid bars: Sample

Note: Population distribution data are drawn from the WHO Regional Office for Europe, OECD and Eurostat joint questionnaire on non-monetary healthcare statistics (data not available for some countries and age groups). Transparent bars indicate population distribution; solid bars represent the survey's sample distribution.

Prevalence of mental health conditions

One in three respondents report symptoms compatible with a major depressive disorder, and one in four an anxiety disorder. Nurses and female doctors are more prone to depression and anxiety, while male doctors report higher prevalence of probable alcohol dependence. These gender differences are consistent with estimates from the general population *(16,17)*.

The aggregated prevalence of depression is slightly higher among nurses (32%). For doctors, the prevalence is seven points higher for females than for males (Fig. 5).

Figure 5. Depression, by profession and gender

Depression	♀ Female	♂ Male	Overall
DOCTORS	30%	23%	28%
NURSES	33%	29%	32%

Note: Prevalence of major depressive disorder is estimated through country-specific thresholds of the PHQ-9.

For anxiety, the prevalence is similar for female and male nurses, but higher among female than among male doctors (Fig. 6).

Figure 6. Anxiety, by profession and gender

Anxiety	♀ Female	♂ Male	Overall
DOCTORS	26%	19%	24%
NURSES	24%	22%	24%

Note: Prevalence of generalized anxiety disorder is estimated through country-specific thresholds of the GAD-7.

The aggregated prevalence of probable alcohol dependence is higher among doctors than among nurses, with male doctors reporting the highest prevalence (Fig. 7).

Figure 7. Alcohol dependence, by profession and gender

Alcohol dependence	Female	Male	Overall
DOCTORS	3%	6%	4%
NURSES	2%	4%	2%

Note: Prevalence of probable alcohol dependence is estimated using a validated threshold on the CAGE screening tool.

Over one in 10 doctors and nurses report thoughts of harming themselves or of suicide

Thirteen per cent of health workers reported suicidal thoughts – feeling that they would be better off dead and/or having thoughts of hurting themselves – in the last two weeks (Fig. 8). Such thoughts are strong predictors of future suicidal behaviour and suicide-related death *(18,19)*. While this finding is based on a single self-reported item and should be interpreted with caution, it nevertheless indicates the scale of the problem.

Figure 8. Prevalence of suicidal thoughts, by profession and gender

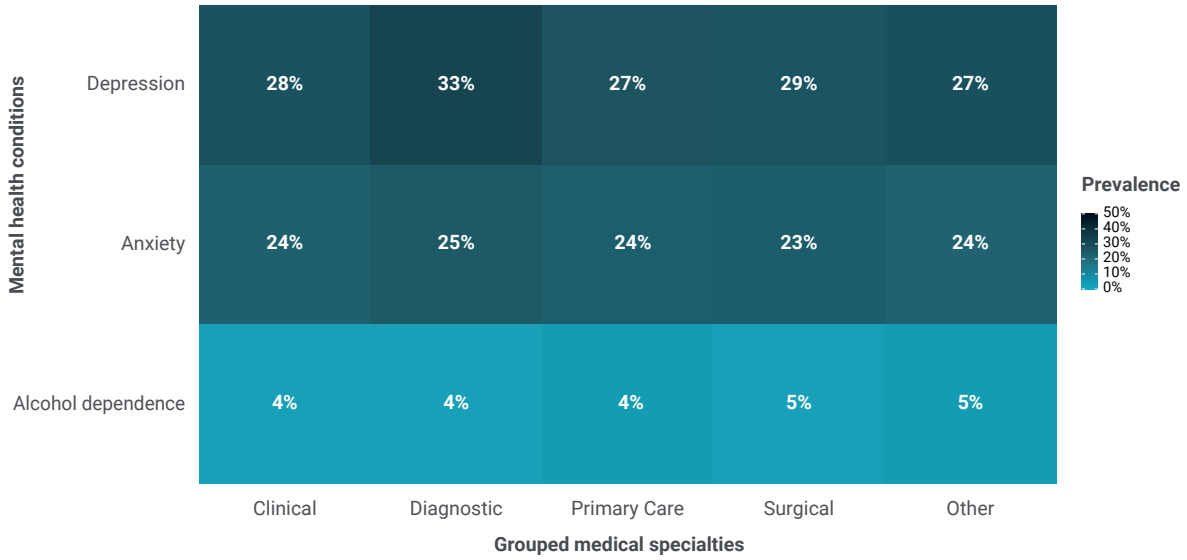
Suicidal thoughts	Female	Male	Overall
DOCTORS	14%	14%	14%
NURSES	13%	15%	13%

Mental health conditions are prevalent amongst doctors and nurses across all settings and specialties. Health workers in inpatient hospital care and emergency departments had the highest levels of anxiety and depression, with prevalence rates ranging from 23–33% for depression and anxiety.

Mental health conditions are highly prevalent across settings and specialties

The prevalence of mental health conditions does not differ greatly by medical specialty, but there was a slightly higher prevalence of both anxiety and depressive symptoms observed among radiologists and other diagnostic specialists (Fig. 9).

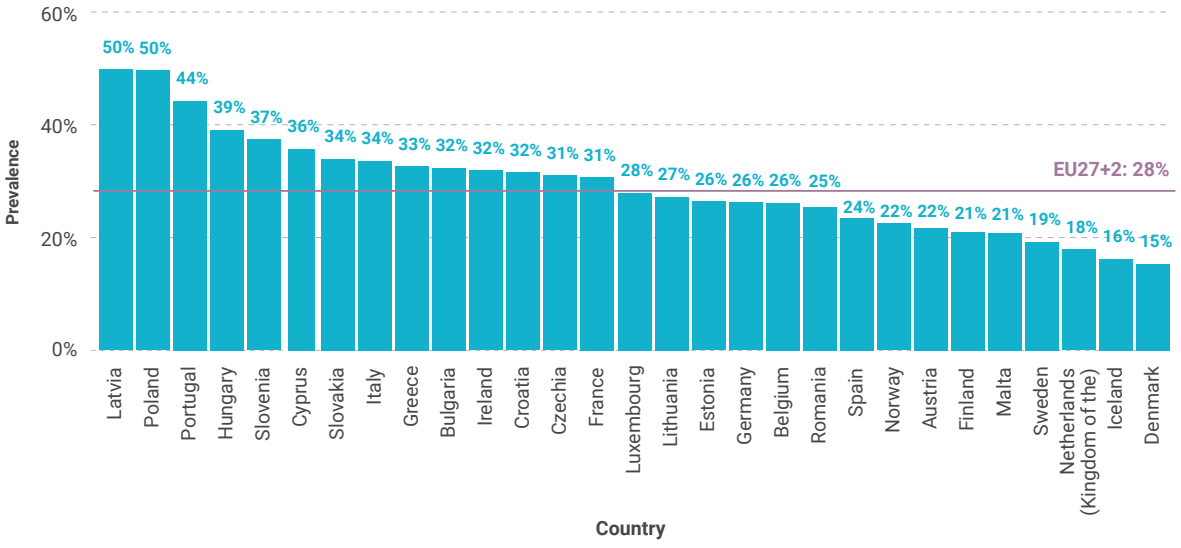
Figure 9. Prevalence of mental health conditions, by medical specialty (doctors only)



Prevalence of depression and anxiety varies significantly across countries

Healthcare workers (HCWs) in Latvia and Poland report the highest rates of depression, with nearly half of the respondents meeting the threshold for probable major depressive disorder. In contrast, workers in Denmark and Iceland show much lower prevalence rates (approximately 15%) (Fig. 10). These rates are consistently higher in every country than rates found using the same instrument in the general population, but the variation between countries does not follow the same trend when compared with the variation in depression rates in the general population (see Discussion).

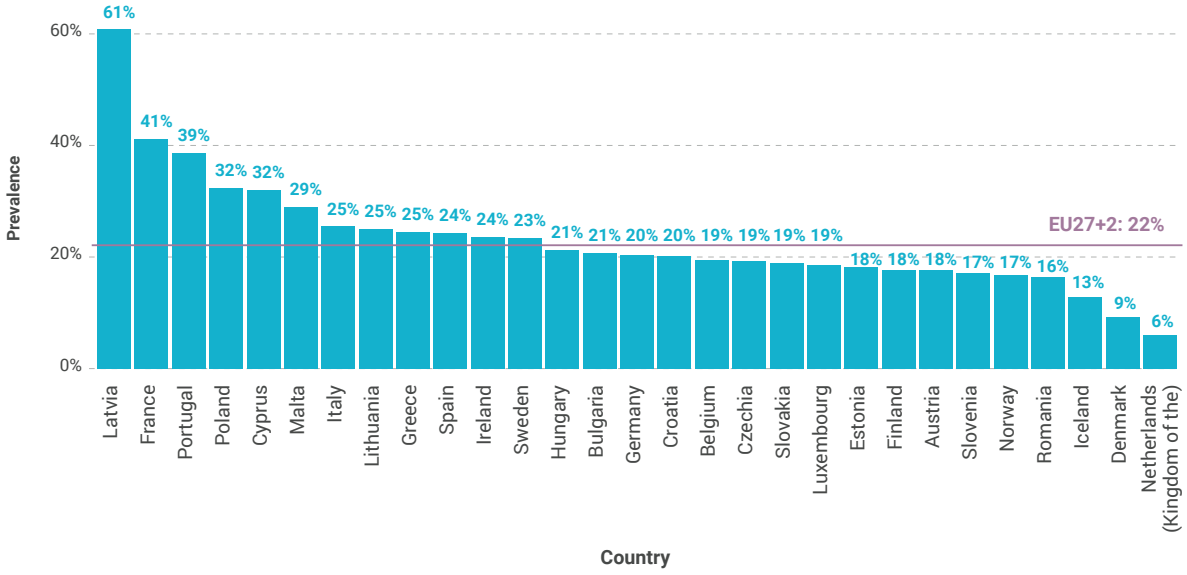
Figure 10. Depression, by country



EU27+2 = European Union, Iceland and Norway
Note: Prevalence of major depressive disorder is estimated through country-specific thresholds of the PHQ-9. The proportion of responses to the MeND survey is below 1% in Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland.

Cross-country variation in anxiety is even higher: in Latvia, nearly two thirds of respondents score above the threshold for anxiety disorders, while in the Denmark and Netherlands (Kingdom of the) the prevalence is below 10%. Notably, there is a 20-percentage point difference between Latvia and France, which ranks second (Fig. 11).

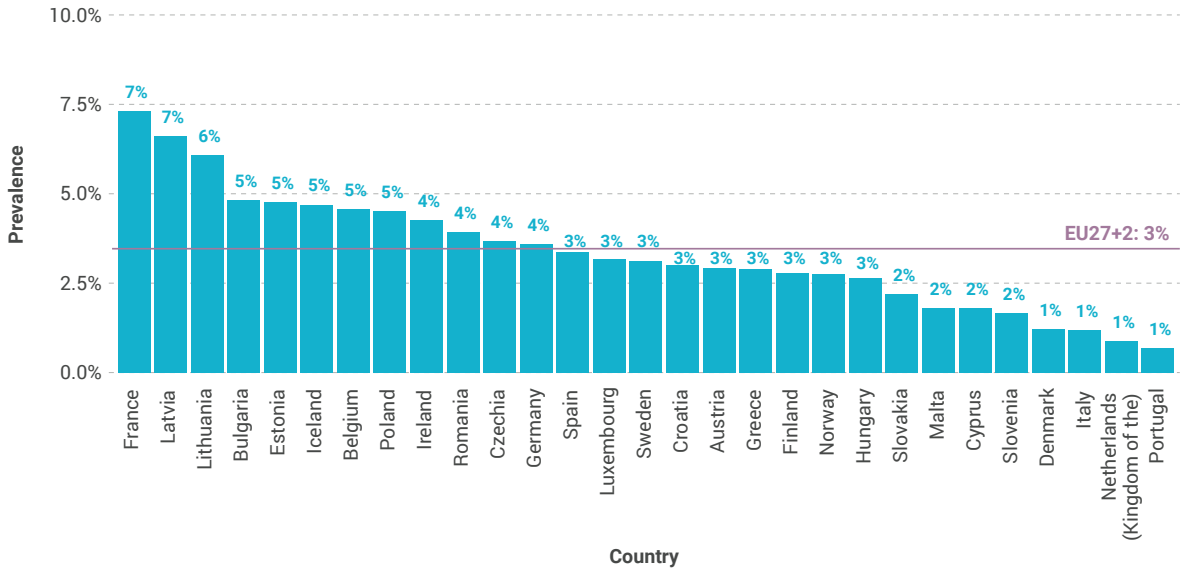
Figure 11. Anxiety, by country



EU27+2 = European Union, Iceland and Norway
Note: Prevalence of generalized anxiety disorder is estimated through a score of 10+ on the GAD-7. The proportion of responses to the MeND survey is below 1% in Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland.

The highest rates of probable alcohol dependence are observed in France, followed by the Baltic countries and Bulgaria (Fig. 12). At the lower end of the scale, no clear geographical pattern emerges, with Denmark, Italy, Netherlands (Kingdom of the) and Portugal showing prevalences of approximately 1%.

Figure 12. Alcohol dependence, by country



EU27+2 = European Union, Iceland and Norway
Note: Prevalence of probable alcohol dependence is estimated using a validated threshold on the CAGE screening tool (see Methods). The proportion of responses to the MeND survey is below 1% in Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland.

Well-being and job satisfaction

Two thirds of doctors and nurses reported feeling satisfied with their jobs. Satisfaction levels are higher among doctors than nurses, and among female nurses than male nurses (Fig. 13).

Figure 13. Job satisfaction, by profession and gender

Job satisfaction	Female	Male	Overall
DOCTORS	69%	72%	70%
NURSES	65%	56%	64%

Most health workers view their role as having purpose and meaning

Two thirds of the respondents find their jobs meaningful and purposeful. Rates are higher for doctors than nurses, and for female nurses than male nurses (Fig. 14 and 15).

Figure 14. Sense of purpose in the workplace, by profession and gender

Purpose	Female	Male	Overall
DOCTORS	74%	74%	74%
NURSES	66%	57%	65%

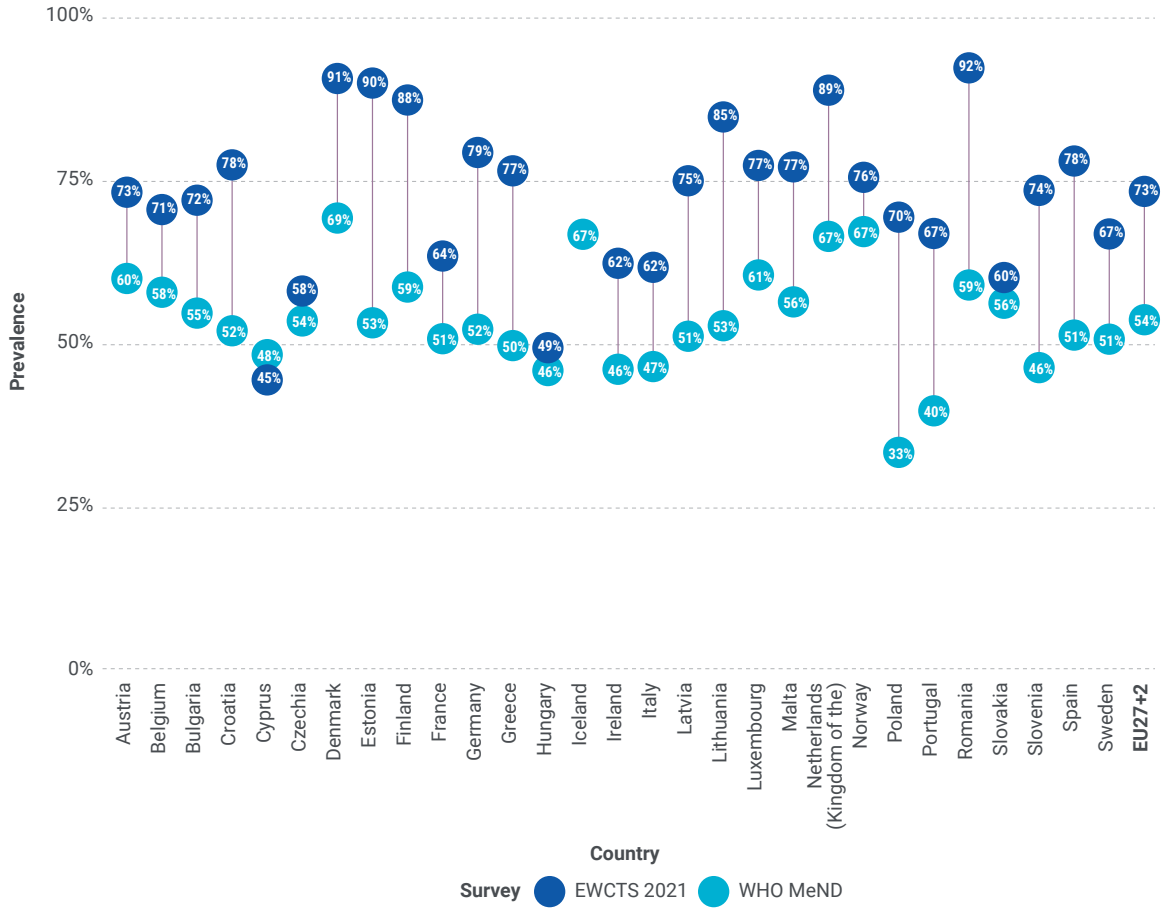
Figure 15. Sense of meaning in the workplace, by profession and gender

Meaning	Female	Male	Overall
DOCTORS	74%	75%	75%
NURSES	61%	48%	59%

Despite a high prevalence of respondents reporting job satisfaction and a sense of purpose and meaning in their work, doctors and nurses reported comparatively lower emotional well-being. This component of well-being includes positive effects and emotions, such as feelings of calm, vigour or rest *(20)*.

Overall, levels of well-being were one third lower than those found among doctors and nurses in the European Working Conditions Telephone Survey conducted in 2021 (EWCTS 2021) using the same instrument *(21)*. This lower level is consistent across countries, ranging from 37 percentage points in Estonia and Poland to 3 points in Cyprus and Hungary (Fig. 16).

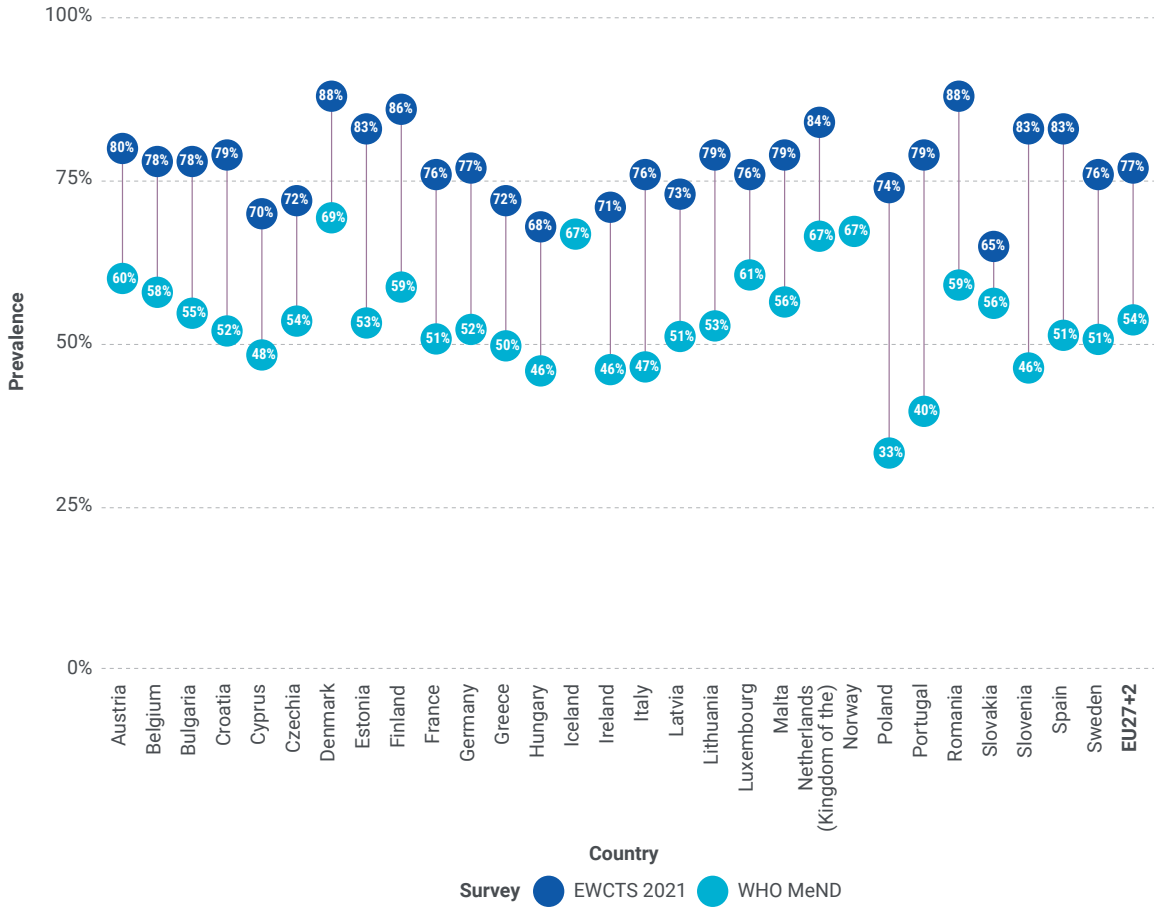
Figure 16. Proportion of doctors and nurses reporting well-being across countries, compared to 2021



Note: Reference data are drawn from EWCTS 2021, conducted by Eurofound (excluding Iceland and Norway) *(21)*. The proportion of responses to the MeND survey is below 1% in Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland.

Doctors and nurses also reported emotional well-being levels that were two thirds lower than those reported by other professions in the same survey (EWCTS 2021), which was consistent across all participating countries. The differences range from 41 percentage points in Poland to 9 points in Slovakia (Fig. 17).

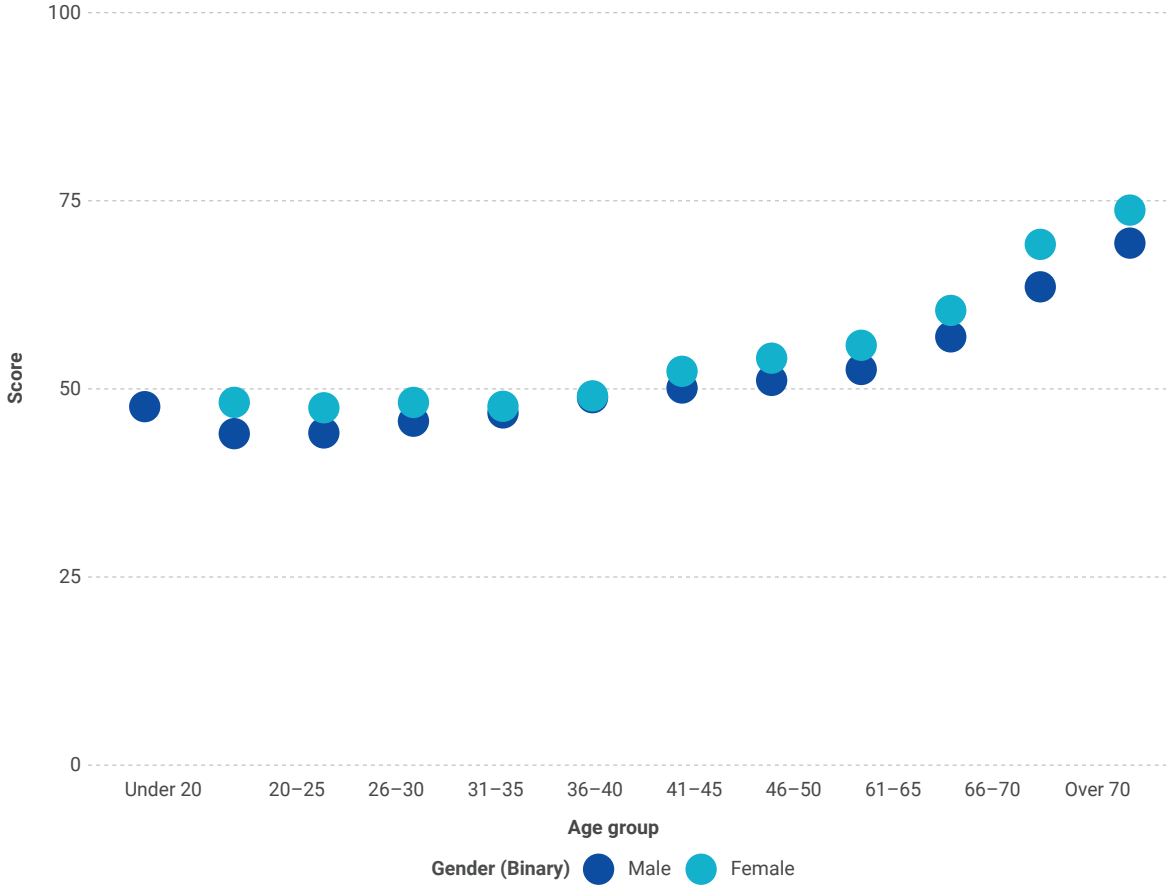
Figure 17. Proportion of doctors and nurses reporting well-being across countries, compared to other professions



Note: Reference data are drawn from EWCTS 2021, conducted by Eurofound (excluding Iceland and Norway) *(21)*. The proportion of responses to the MeND survey is below 1% in Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland.

Respondents older than 60 years of age reported higher well-being, with similar trends observed for female and male HCWs (Fig. 18).

Figure 18. Emotional well-being, by age and gender



Note: Well-being scores computed using the World Health Organization-Five Well-Being Index (WHO-5).

Working conditions

The MeND survey explores four domains of potentially actionable workplace risk and protective factors: exposure to violence, working hours and contracts, social support and control and workplace support structures (Fig. 19).

Table 1. Overview of the working conditions included in the survey

Exposure to violence	Working hours and contracts	Social support and control	Workplace support structures
Bullying	Extended hours (>50 hours per week)	Support from colleagues	Mechanisms for employee feedback
Managing patient and relative anger	Frequent night shifts	Support from superiors	Work council or union
Physical violence	Frequent rotating shifts	Influence over work	Workplace harassment protocol
Sexual harassment	Temporary contracts	Influence over work (breaks)	Workplace stress action plan
Violent threats		Work–life balance	Workplace violence protocol

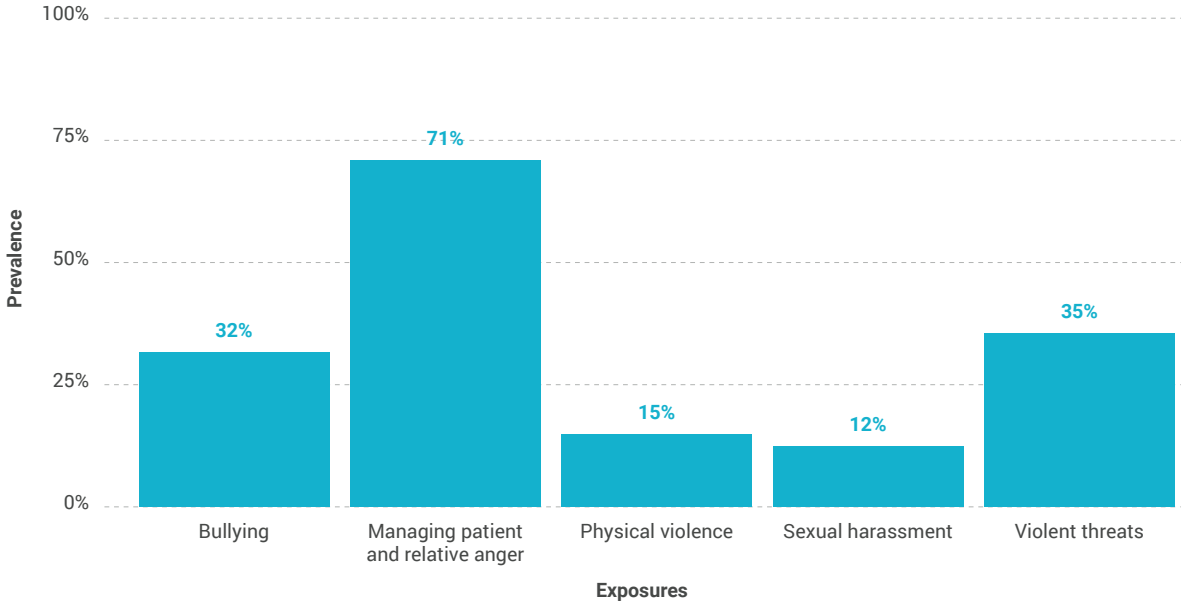
Note: For details, see Annex 1: Methodology.

Exposure to violence

Violence against health workers is common. Seventy per cent of doctors and nurses report being frequently exposed to angry patients or relatives at their workplaces. One third of doctors and nurses reported being exposed to bullying or violent threats at their workplace and more than 10% reported physical violence and sexual harassment (Fig. 19).

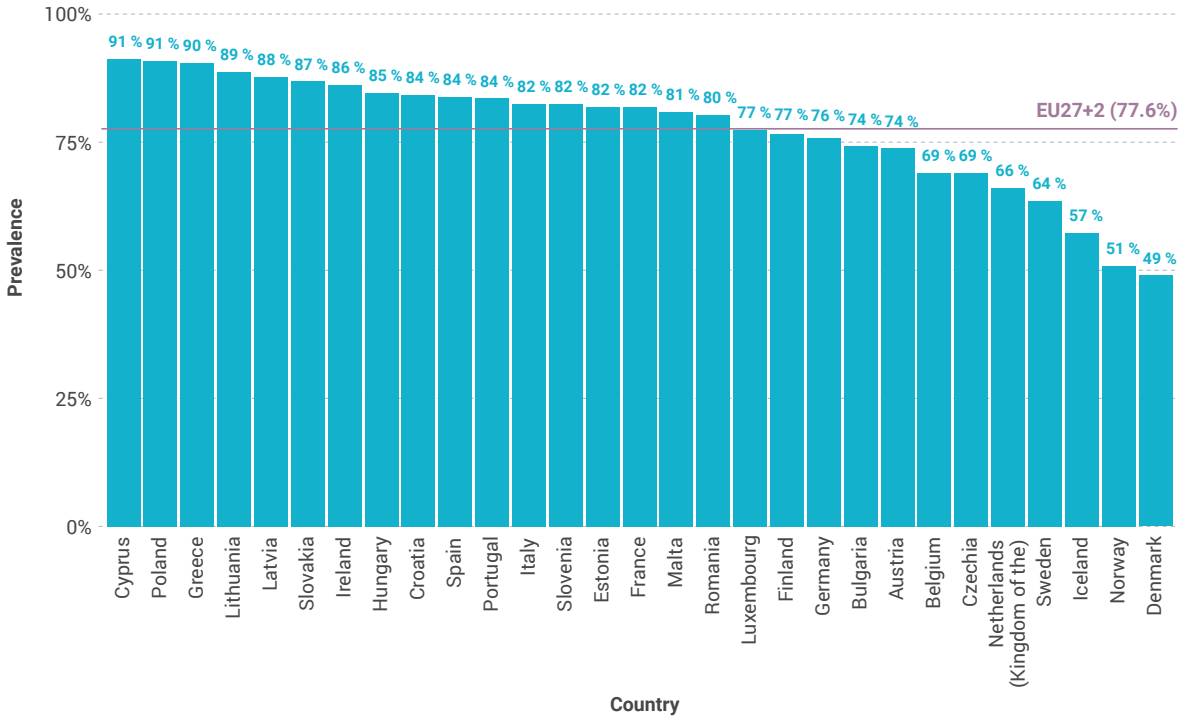
Violence against health workers is consistently high across countries and settings

Figure 19. Proportion of workers exposed to violence in the workplace



Over half of the respondents reported at least one type of violence in the workplace. Although there were large differences across countries (for example, 49% in Denmark vs 91% in Cyprus and Poland), the proportions are in general significant (Fig. 20).

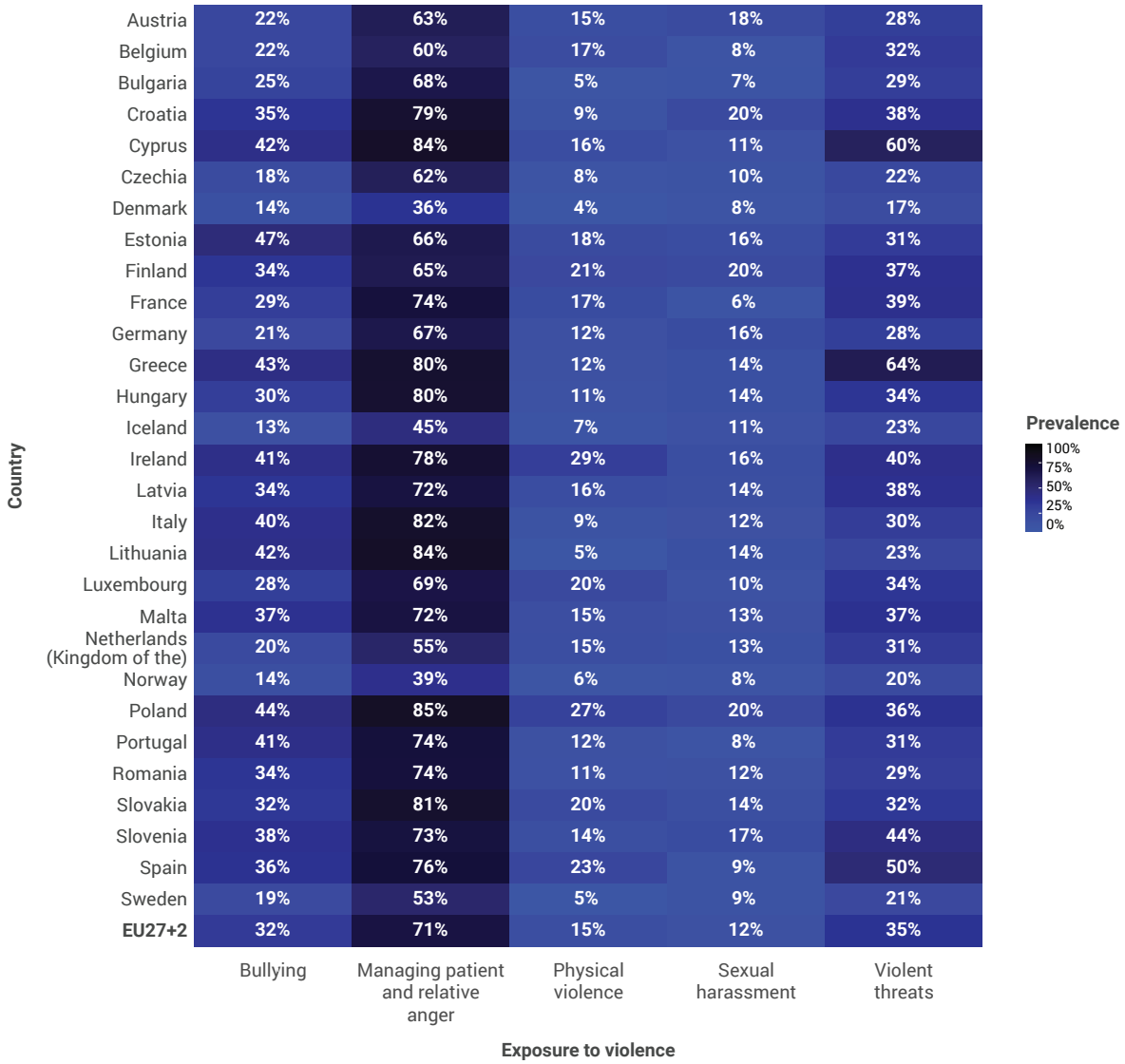
Figure 20. Proportion of workers exposed to at least one type of violence in the workplace, by country



Note: The proportion of responses to the MeND survey is below 1% in Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland.

Exposure to violent threats was highest in Cyprus, Greece and Spain; sexual harassment was highest in Croatia, Finland and Poland; physical violence was highest in Ireland, Poland and Spain; angry patients and relatives were highest in Cyprus, Lithuania and Poland; and bullying was highest in Estonia, Greece and Poland (Fig. 21).

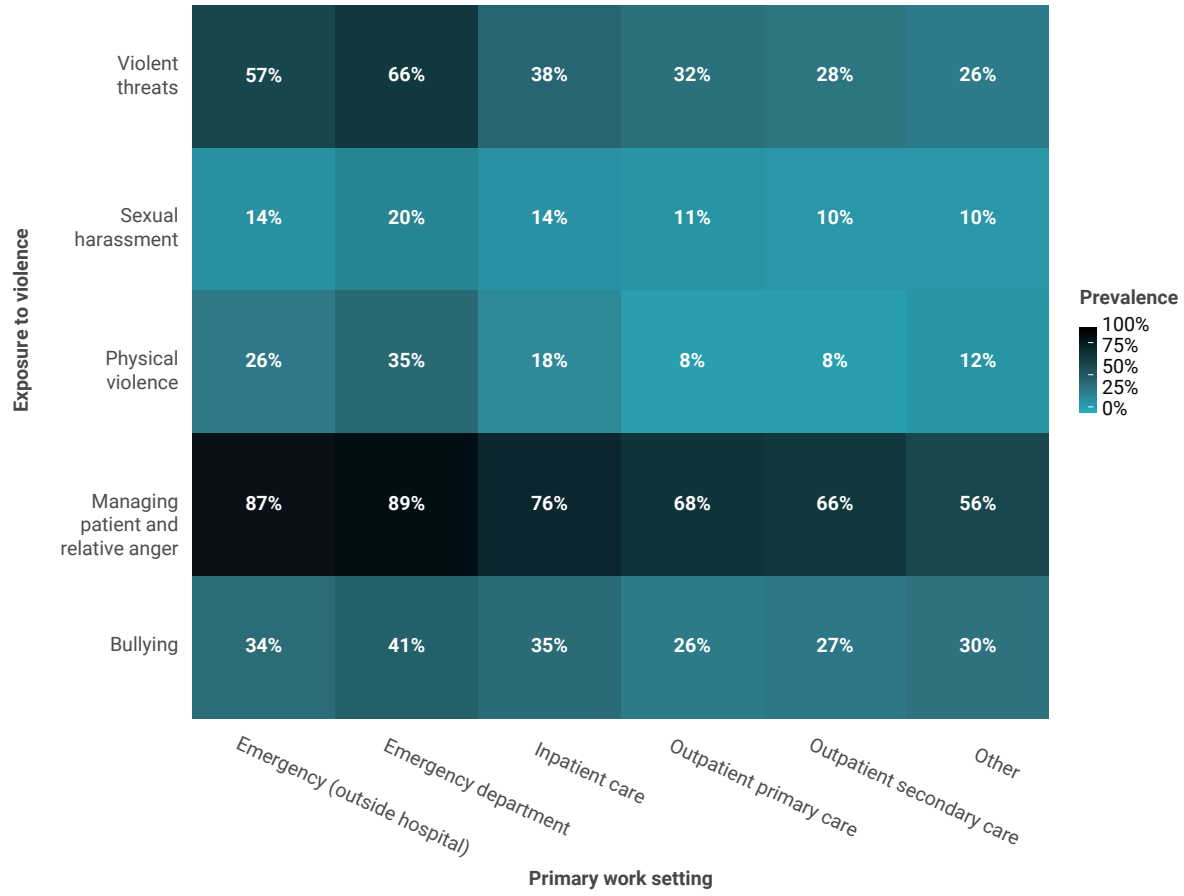
Figure 21. Proportion of workers exposed to violence, by country


Country
Austria 22% 63% 15% 18% 28%
Belgium 22% 60% 17% 8% 32%
Bulgaria 25% 68% 5% 7% 29%
Croatia 35% 79% 9% 20% 38%
Cyprus 42% 84% 16% 11% 60%
Czechia 18% 62% 8% 10% 22%
Denmark 14% 36% 4% 8% 17%
Estonia 47% 66% 18% 16% 31%
Finland 34% 65% 21% 20% 37%
France 29% 74% 17% 6% 39%
Germany 21% 67% 12% 16% 28%
Greece 43% 80% 12% 14% 64%
Hungary 30% 80% 11% 14% 34%
Iceland 13% 45% 7% 11% 23%
Ireland 41% 78% 29% 16% 40%
Latvia 34% 72% 16% 14% 38%
Italy 40% 82% 9% 12% 30%
Lithuania 42% 84% 5% 14% 23%
Luxembourg 28% 69% 20% 10% 34%
Malta 37% 72% 15% 13% 37%
Netherlands (Kingdom of the) 20% 55% 15% 13% 31%
Norway 14% 39% 6% 8% 20%
Poland 44% 85% 27% 20% 36%
Portugal 41% 74% 12% 8% 31%
Romania 34% 74% 11% 12% 29%
Slovakia 32% 81% 20% 14% 32%
Slovenia 38% 73% 14% 17% 44%
Spain 36% 76% 23% 9% 50%
Sweden 19% 53% 5% 9% 21%
EU27+2 32% 71% 15% 12% 35%
Bullying
Managing patient and relative anger
Physical violence
Sexual harassment
Violent threats
Exposure to violence
Prevalence
100%
75%
50%
25%
0%

Note: The proportion of responses to the MeND survey is below 1% in Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland.

Exposure to violence was similarly prevalent across different settings. Emergency doctors and nurses, both inside and outside hospitals, are among those most exposed to violence (Fig. 22).

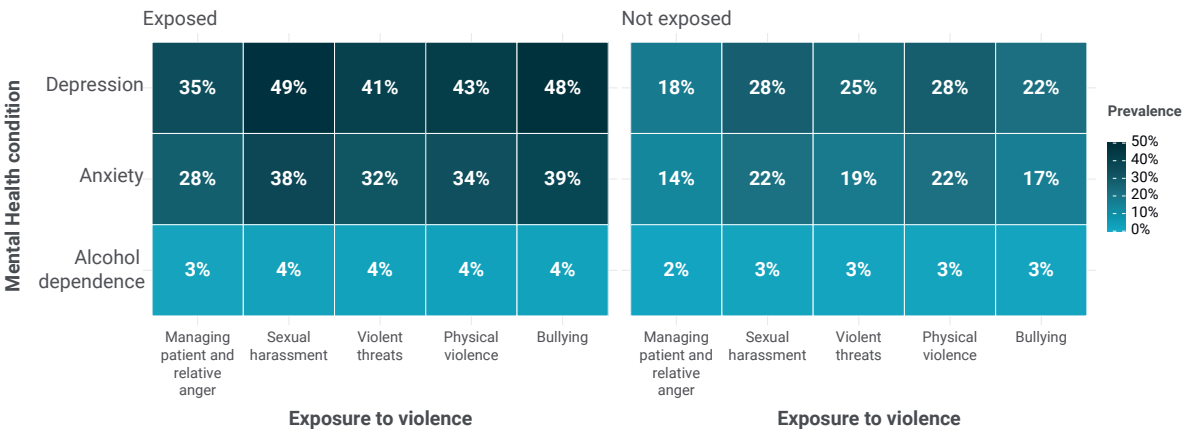
Figure 22. Proportion of workers exposed to violence, by setting



Violence exposure is linked to higher rates of mental health conditions

Doctors and nurses exposed to violence report poorer mental health and a greater prevalence of alcohol dependence. The poorest mental health was found among those exposed to sexual harassment and bullying (Fig. 23).

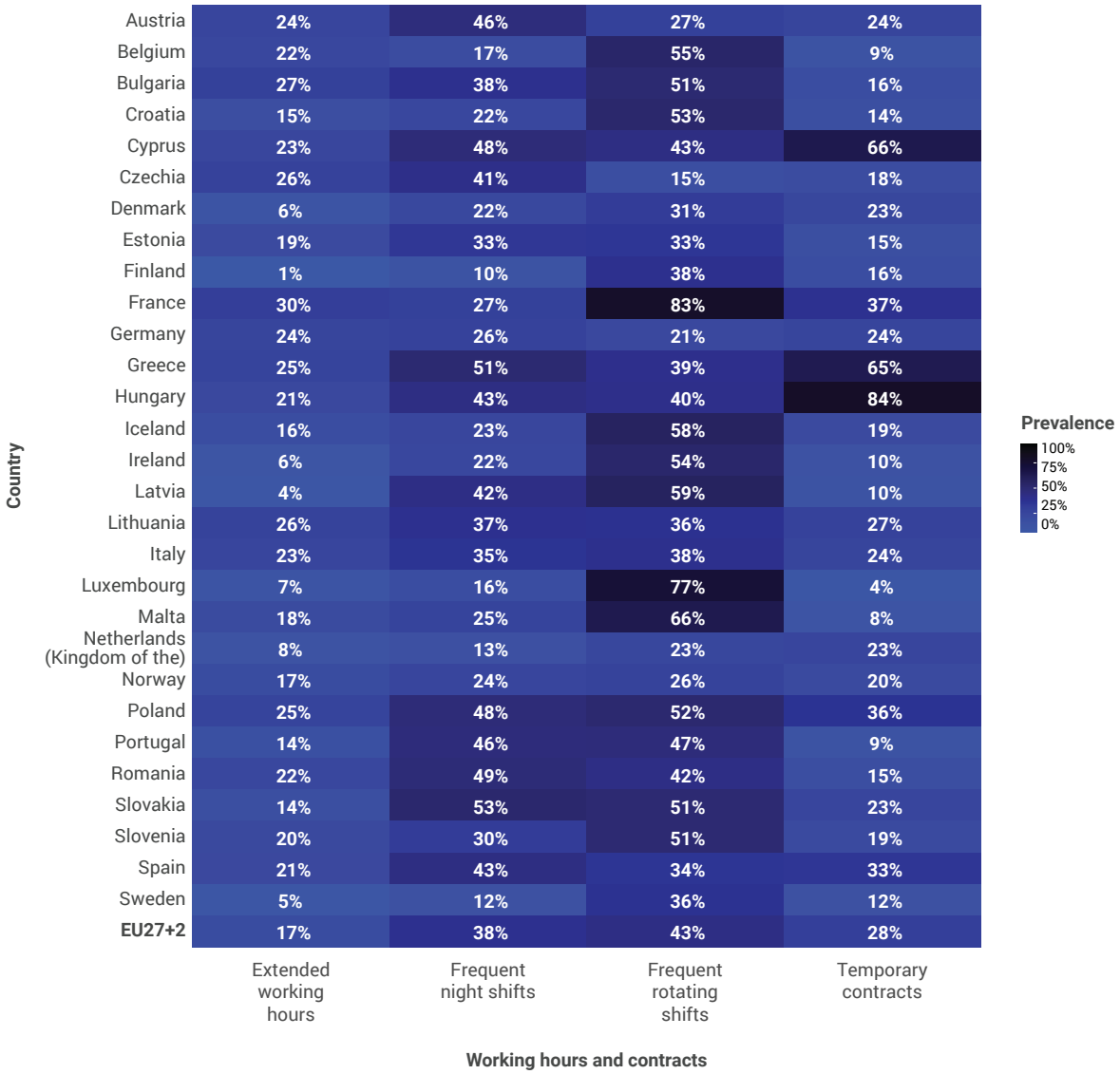
Figure 23. Prevalence of mental health conditions, by exposure to violence



Working hours and contracts

Levels of exposure to risk factors related to working hours and contracts vary across countries. The most prevalent exposures overall were frequent rotating shifts and night shifts; countries with the highest prevalence of combined rotating and night shifts are France (93%), Greece (90%) and Hungary (94%) (Fig. 24).

Figure 24. Proportion of people who work extended hours (>50 hours/week), regularly do rotating shifts and/or night shifts and hold temporary contracts, by country

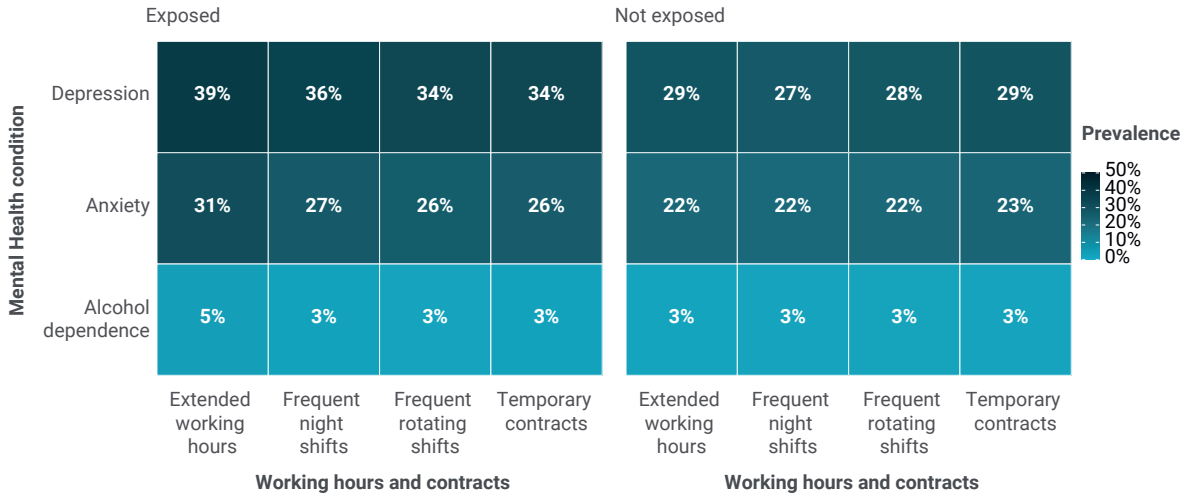

Country
Austria 24% 46% 27% 24%
Belgium 22% 17% 55% 9%
Bulgaria 27% 38% 51% 16%
Croatia 15% 22% 53% 14%
Cyprus 23% 48% 43% 66%
Czechia 26% 41% 15% 18%
Denmark 6% 22% 31% 23%
Estonia 19% 33% 33% 15%
Finland 1% 10% 38% 16%
France 30% 27% 83% 37%
Germany 24% 26% 21% 24%
Greece 25% 51% 39% 65%
Hungary 21% 43% 40% 84%
Iceland 16% 23% 58% 19%
Ireland 6% 22% 54% 10%
Latvia 4% 42% 59% 10%
Lithuania 26% 37% 36% 27%
Italy 23% 35% 38% 24%
Luxembourg 7% 16% 77% 4%
Malta 18% 25% 66% 8%
Netherlands (Kingdom of the) 8% 13% 23% 23%
Norway 17% 24% 26% 20%
Poland 25% 48% 52% 36%
Portugal 14% 46% 47% 9%
Romania 22% 49% 42% 15%
Slovakia 14% 53% 51% 23%
Slovenia 20% 30% 51% 19%
Spain 21% 43% 34% 33%
Sweden 5% 12% 36% 12%
EU27+2 17% 38% 43% 28%
Extended working hours
Frequent night shifts
Frequent rotating shifts
Temporary contracts
Working hours and contracts
Prevalence
100%
75%
50%
25%
0%

EU27+2 = European Union, Iceland and Norway
Note: The proportion of responses to the MeND survey is below 1% in Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland.

Stable hours and contracts are associated with better mental health

Doctors and nurses exposed to less stable working hours and contracts – such as frequent extended working hours, night shifts, rotating shifts and temporary contracts – report higher rates of anxiety and depression, as well as increased prevalence of alcohol dependence. In contrast, health workers with more stable work conditions report significantly fewer mental health issues (Fig. 25).

Figure 25. Prevalence of mental health conditions, by exposure to workplace risk factors (working hours and contracts)



Many doctors work in excess of recommended working hours

Overall, 16% of respondents report working extended hours, defined as more than 50 working hours per week (Fig. 26). The proportion of extended working hours is higher among doctors than among nurses (28% vs 9%) (Fig. 27).

Figure 26. Weekly working hours, by profession

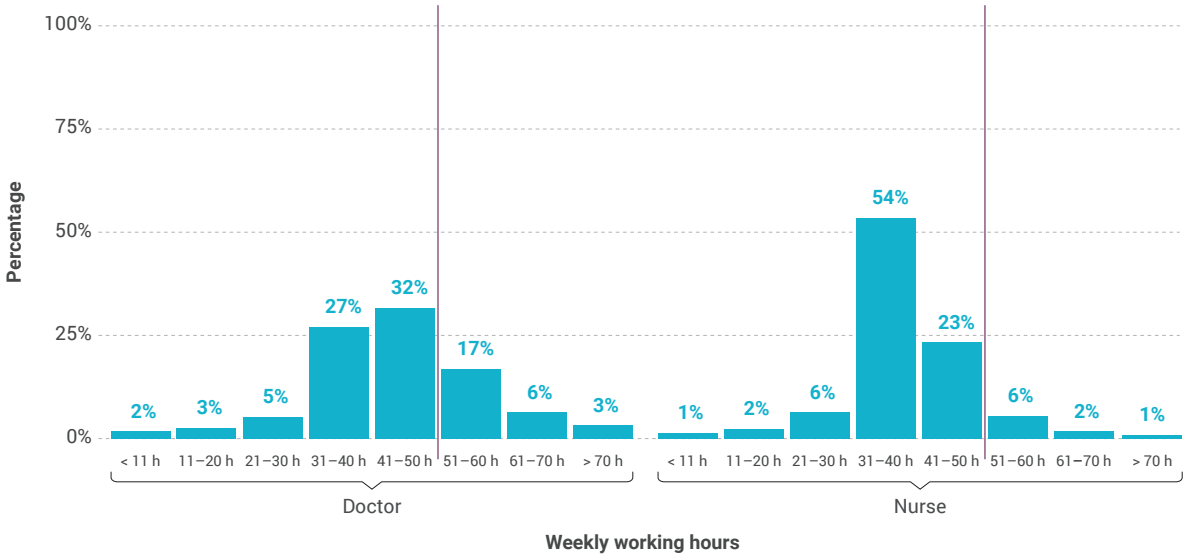
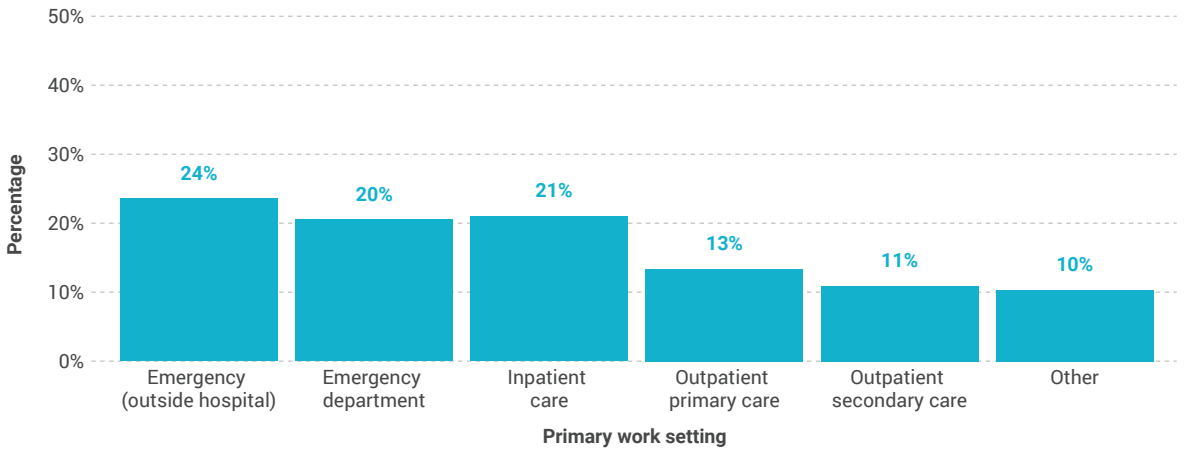


Figure 27. Proportion of people who work extended hours (>50 hours/week), by profession and gender

Extended working hours (>50 hours/week)	Female	Male	Overall
DOCTORS	25%	35%	28%
NURSES	8%	11%	9%

Nearly one in four emergency doctors and nurses reported extended working hours (>50 hours per week). Extended working hours are most common in emergency settings – both in-hospital emergency departments and out-of-hospital settings (such as ambulances) – reaching nearly 25%, which is double that of outpatient secondary care services (Fig. 28).

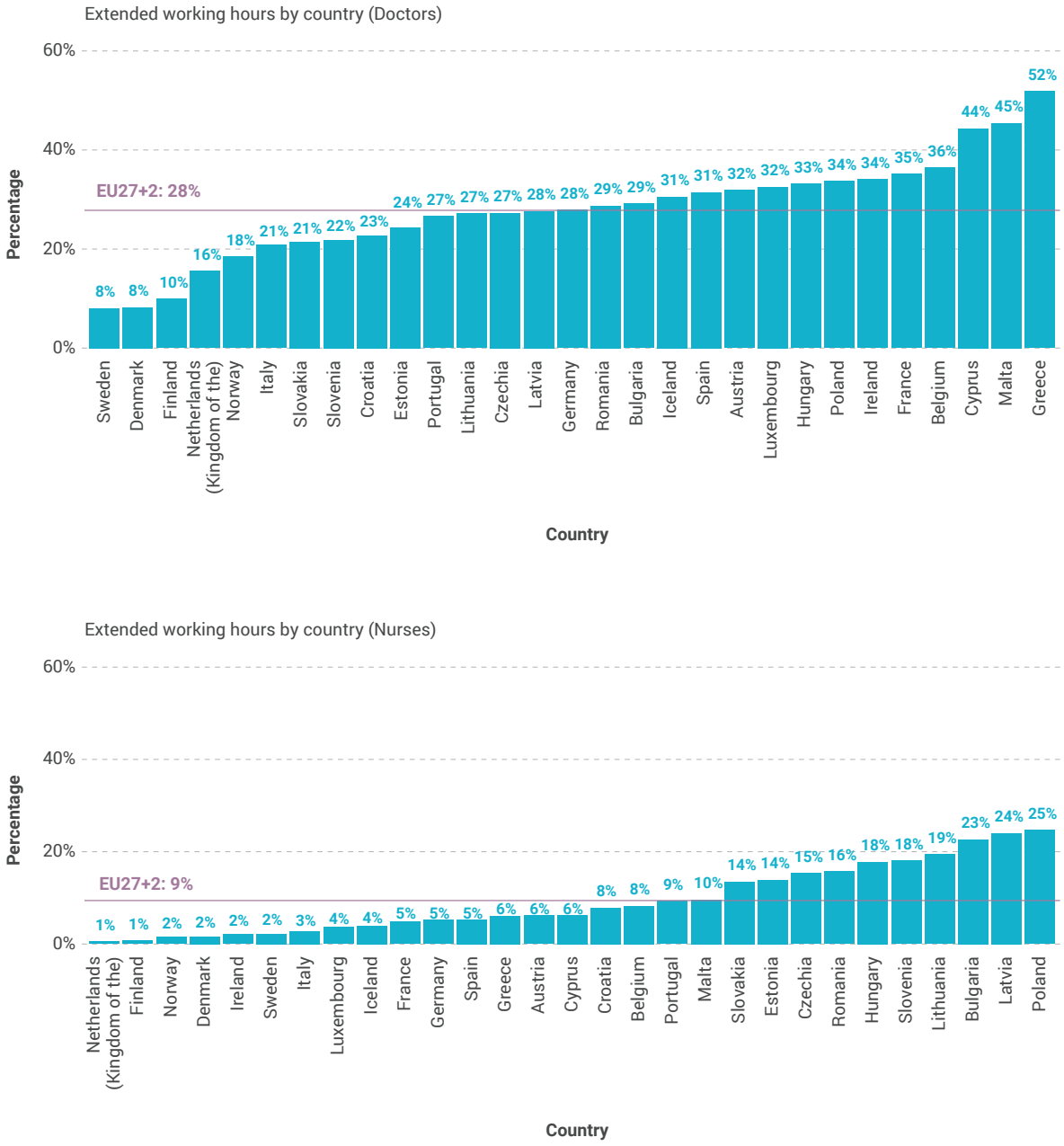
Figure 28. Proportion of people who work extended hours (>50 hours/week), by setting



Extended working hours vary greatly between countries. Among doctors, the proportion that reported extended working hours was more than five times higher in Greece (52%) than in Denmark, Finland or Sweden (8–10%). The disparity is even greater among nurses, with just 1% reporting extended hours in Finland and Netherlands (Kingdom of the), compared to 25% in Latvia and Poland (Fig. 29).

Longer working hours are consistently associated with poorer mental health

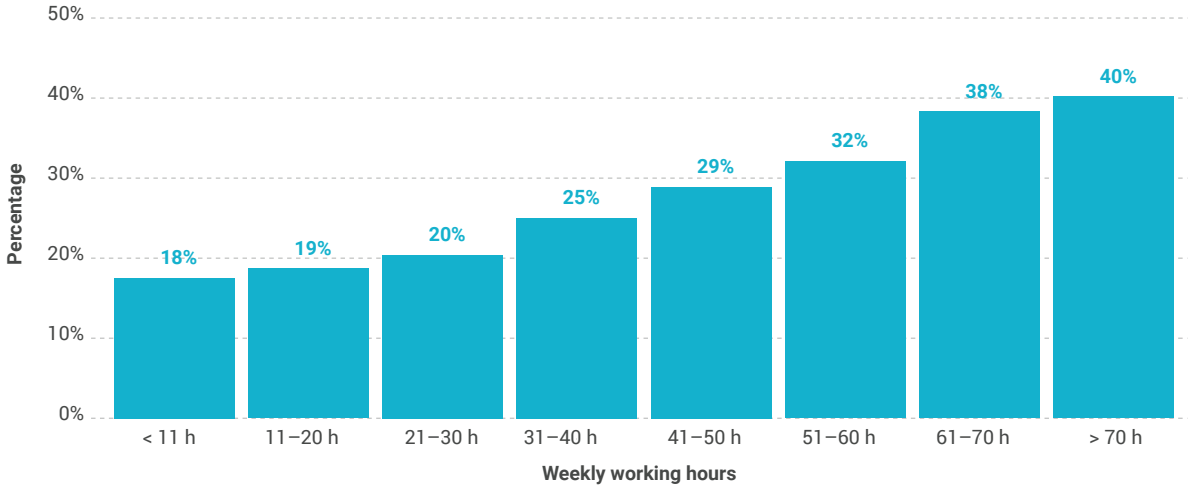
Figure 29. Proportion of people who work extended hours (>50 hours/week), by profession and country



Note: The proportion of responses to the MeND survey is below 1% in Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland.

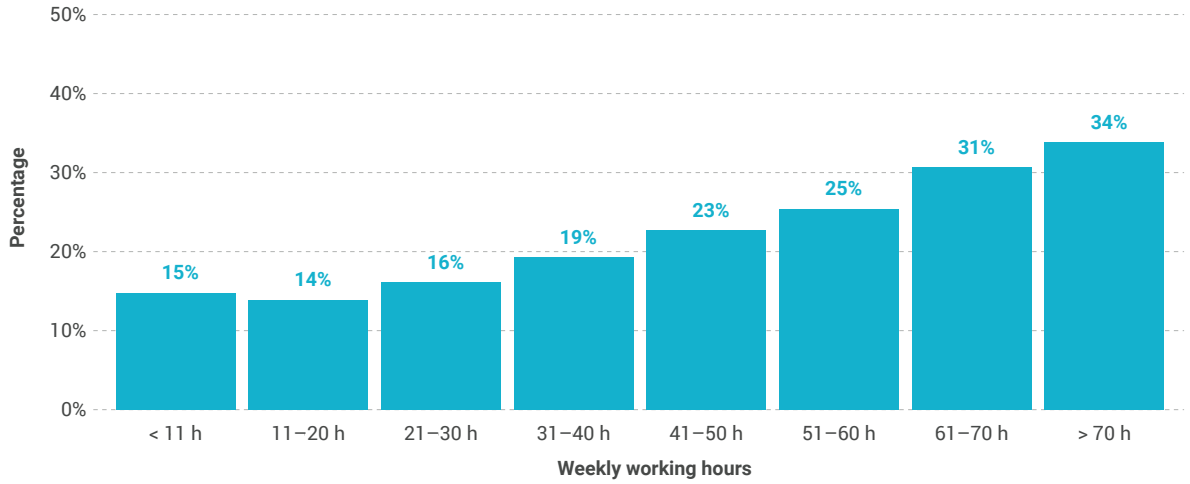
Extended working hours are associated with increased prevalence of depression, anxiety and alcohol dependence, after accounting for country-level differences, gender, age and profession (doctor vs nurse). Values range from 18%, 15% and 3% for depression, anxiety and alcohol dependence among people working less than 11 hours, respectively, to 40%, 34% and 5% among people working more than 70 hours. The prevalence of depression is 29% among those working less than 50 hours per week and 39% among those working more (Fig. 30, 31 and 32).

Figure 30. Depression, by working hours



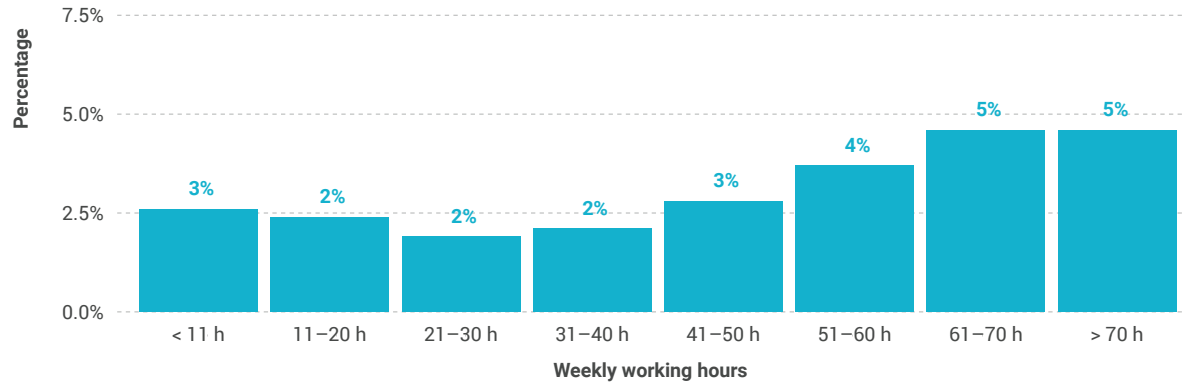
Note: Prevalence of major depressive disorder is estimated through country-specific thresholds of the PHQ-9.

Figure 31. Anxiety, by working hours



Note: Prevalence of generalized anxiety disorder is estimated through country-specific thresholds on the GAD-7.

Figure 32. Alcohol dependence, by working hours



Note: Prevalence of alcohol dependence is estimated using a validated threshold on the CAGE screening tool.

Doctors and nurses working regular shift work report worse mental health

Shift work is defined as working outside the typical hours of 07:00 to 18:00, including working rotating shifts or night shifts.

More than 20% of doctors and 50% of nurses report regular shift work, with over 30% working night shifts weekly or more frequently (Fig. 33 and 34).

Figure 33. Proportion of people who regularly work rotating shifts, by profession and gender

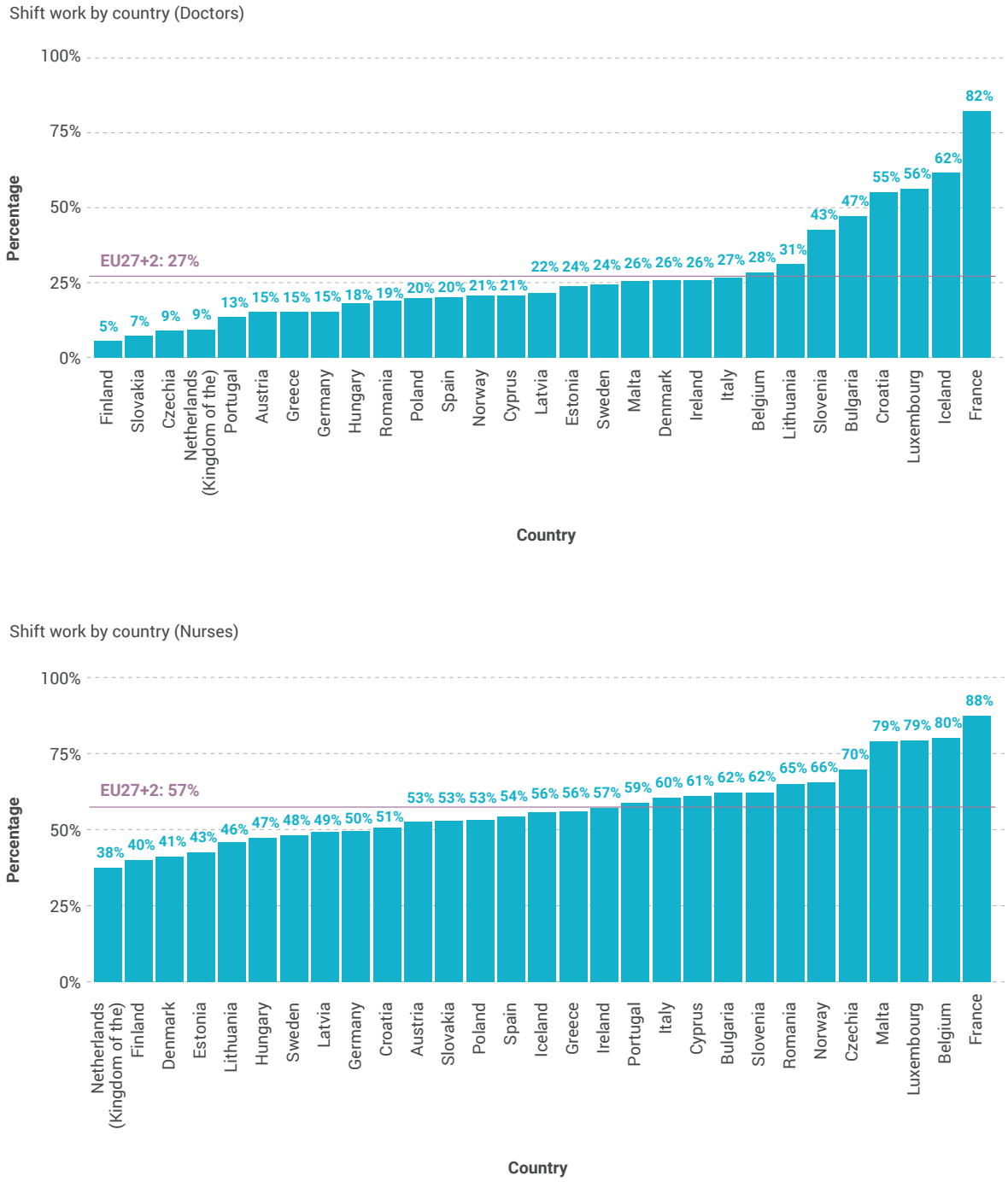
Regular shift work	Female	Male	Overall
DOCTORS	24%	23%	24%
NURSES	55%	65%	56%

Figure 34. Proportion of people who frequently work nights, by profession and gender

Frequent night shifts	Female	Male	Overall
DOCTORS	33%	40%	35%
NURSES	37%	50%	39%

The prevalence of shift work varies significantly across countries. In Finland, 5% of doctors and 40% of nurses worked in shifts, compared to 82% and 88% in France (Fig. 35).

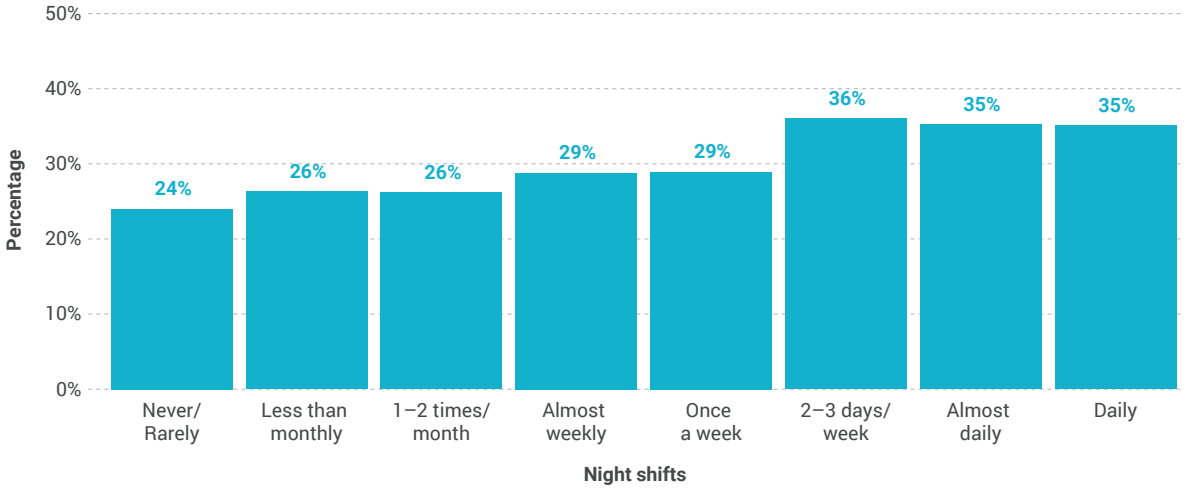
Figure 35. Proportion of people who regularly work shifts, by country



Note: The proportion of responses to the MeND survey is below 1% in Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland.

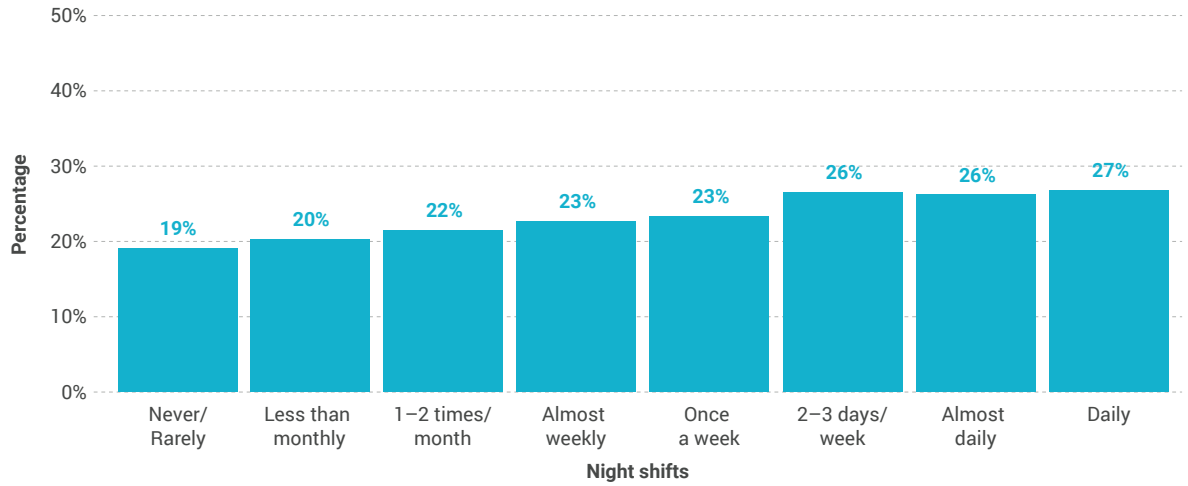
The association between shift work and poor mental health is well established *(22,23)*. The MeND results largely support past findings: the frequency of night work was negatively associated with mental health outcomes, with shift workers being more likely to report symptoms of anxiety and depression (Fig. 36 and 37).

Figure 36. Prevalence of depression, by night shift frequency



Note: Prevalence of major depressive disorder is estimated through country-specific thresholds of the PHQ-9.

Figure 37. Prevalence of anxiety, by night shift frequency



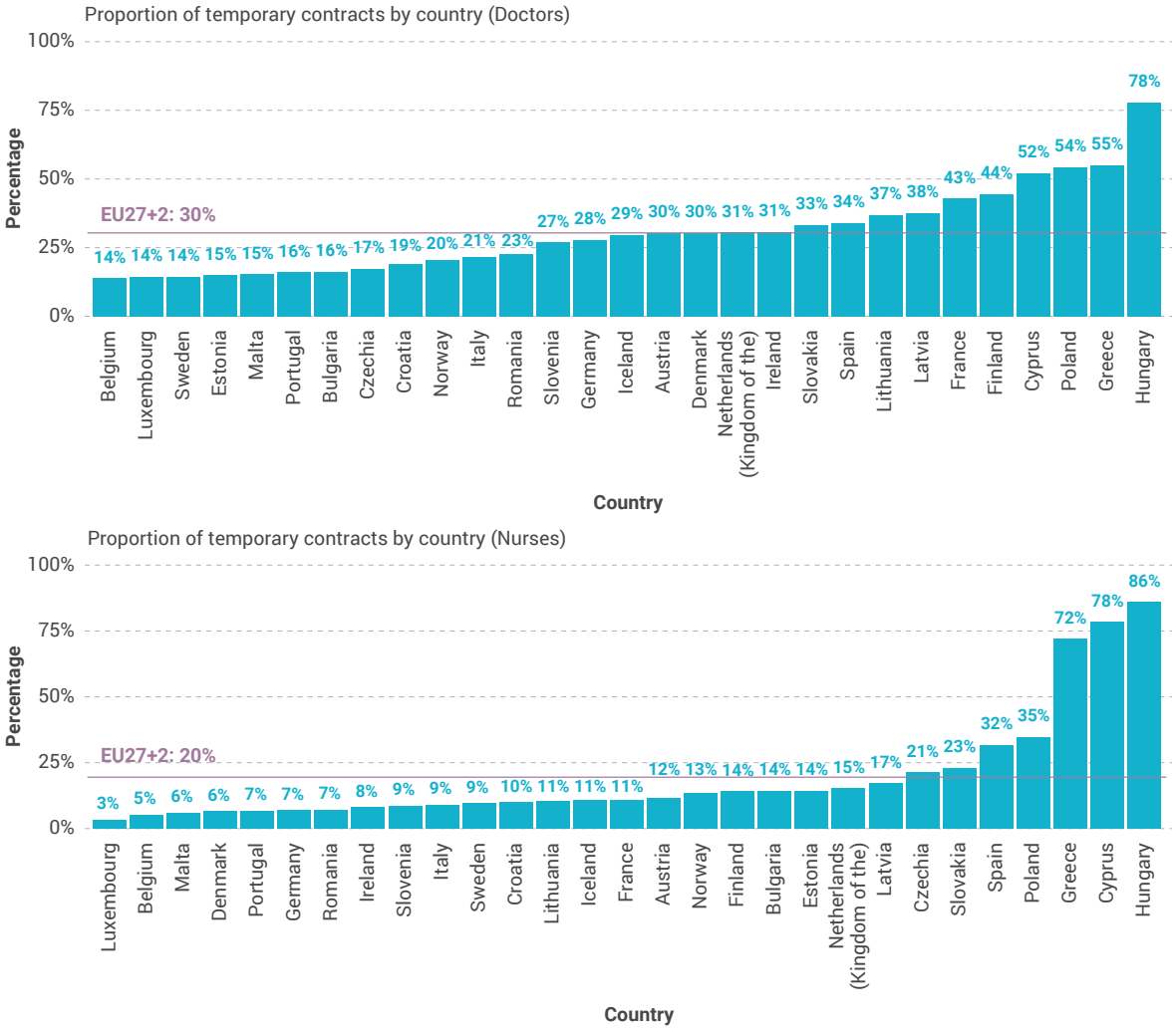
Note: Prevalence of generalized anxiety disorder is estimated through country-specific thresholds on the GAD-7.

One in three doctors and one in four nurses hold temporary contracts (Fig. 38). The proportion varies significantly by country, ranging from 14% to over 78% for doctors, and from 3% to over 86% for nurses (Fig. 39).

Figure 38. Proportion of doctors and nurses with temporary contracts (non-permanent job positions)

Temporary contract	Female	Male	Overall
DOCTORS	32%	30%	31%
NURSES	25%	22%	25%

Figure 39. Proportion of doctors and nurses with temporary contracts (i.e., non-permanent job positions), by country

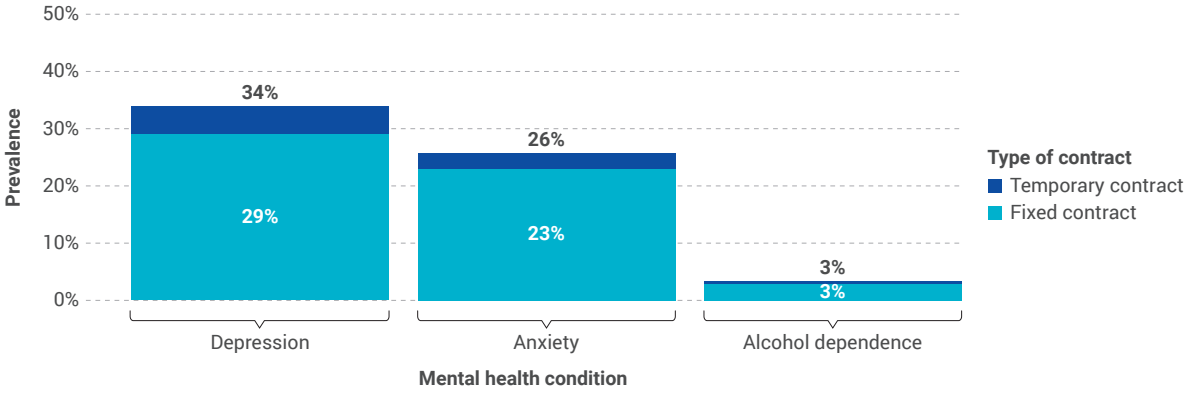


Note: The proportion of responses to the MeND survey is below 1% in Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland.

Greater job insecurity is associated with poorer mental health

Mental health conditions were more prevalent among people with temporary contracts compared to those with permanent contracts (Fig. 40).

Figure 40. Prevalence of probable mental health conditions, by type of contract



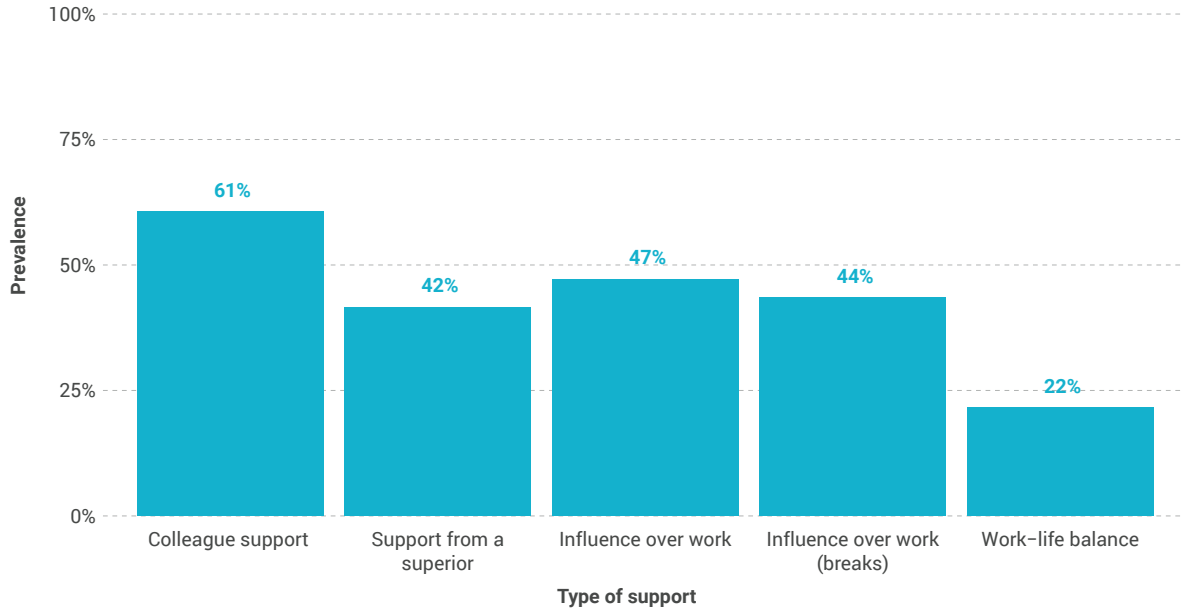
The prevalence of probable alcohol dependence is similar in both groups

Social support and control

Peer support is high, but work–life balance and sense of autonomy are low

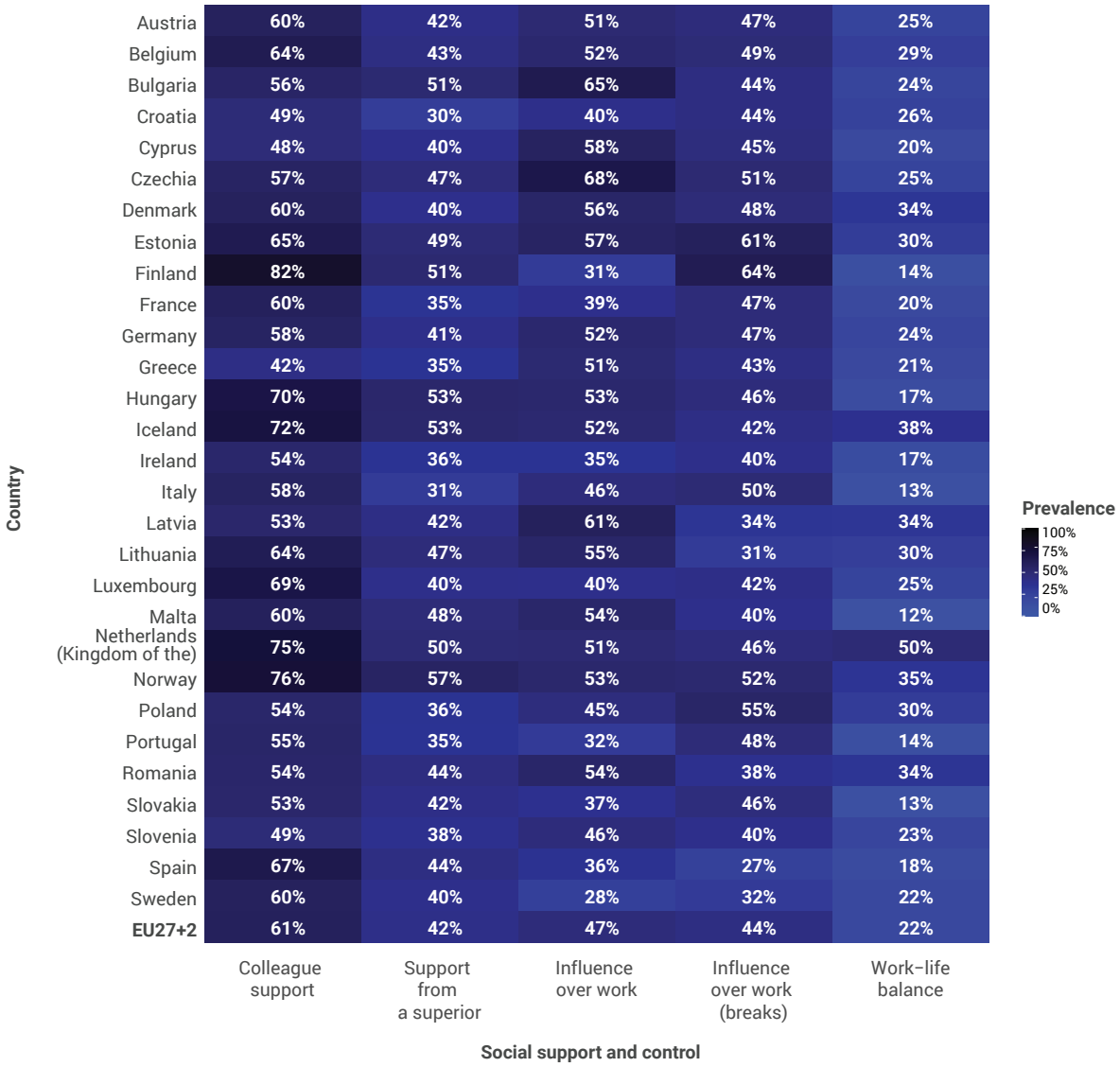
Less than half of the respondents report having influence over their work (including being able to decide when to take a break) or feeling supported by their superiors, and less than 25% think that their job enables work–life balance. The most frequent protective factor is perceived support from colleagues, reported by two thirds of respondents, and one in three reported feeling supported by their superiors (Fig. 41).

Figure 41. Proportion of workers reporting social support and control



These prevalence rates are relatively consistent across countries, with work–life balance showing the lowest rates and support from colleagues showing the highest (Fig. 42).

Figure 42. Proportion of workers reporting social support and control, by country


Country
Austria 60% 42% 51% 47% 25%
Belgium 64% 43% 52% 49% 29%
Bulgaria 56% 51% 65% 44% 24%
Croatia 49% 30% 40% 44% 26%
Cyprus 48% 40% 58% 45% 20%
Czechia 57% 47% 68% 51% 25%
Denmark 60% 40% 56% 48% 34%
Estonia 65% 49% 57% 61% 30%
Finland 82% 51% 31% 64% 14%
France 60% 35% 39% 47% 20%
Germany 58% 41% 52% 47% 24%
Greece 42% 35% 51% 43% 21%
Hungary 70% 53% 53% 46% 17%
Iceland 72% 53% 52% 42% 38%
Ireland 54% 36% 35% 40% 17%
Italy 58% 31% 46% 50% 13%
Latvia 53% 42% 61% 34% 34%
Lithuania 64% 47% 55% 31% 30%
Luxembourg 69% 40% 40% 42% 25%
Malta 60% 48% 54% 40% 12%
Netherlands (Kingdom of the) 75% 50% 51% 46% 50%
Norway 76% 57% 53% 52% 35%
Poland 54% 36% 45% 55% 30%
Portugal 55% 35% 32% 48% 14%
Romania 54% 44% 54% 38% 34%
Slovakia 53% 42% 37% 46% 13%
Slovenia 49% 38% 46% 40% 23%
Spain 67% 44% 36% 27% 18%
Sweden 60% 40% 28% 32% 22%
EU27+2 61% 42% 47% 44% 22%
Colleague support
Support from a superior
Influence over work
Influence over work (breaks)
Work–life balance
Social support and control
Prevalence
100%
75%
50%
25%
0%

Note: The proportion of responses to the MeND survey is below 1% in Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland.

Less support is linked to worse mental health

The proportion of respondents who report feeling supported at work varies across countries, from 40% to 80% for colleague support, and from 30% to 60% for support from superiors. Our findings now show an inverse association between social support and anxiety and depression, with lower levels of support from both colleagues and superiors linked to poorer mental health (Fig. 43 and 44).

Figure 43. Prevalence of mental health conditions, by perceived frequency of support from colleagues

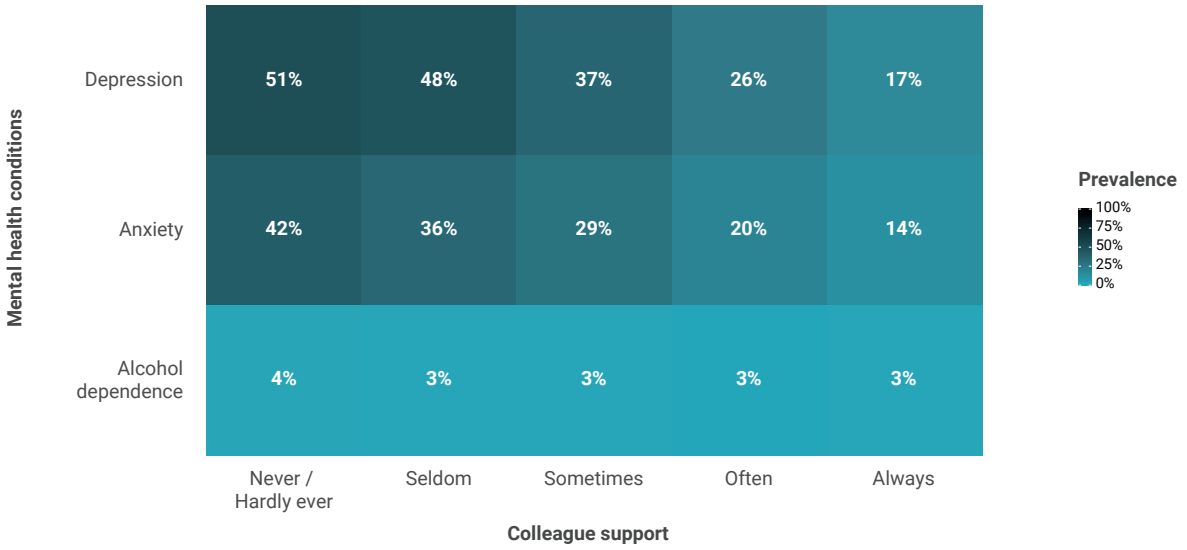
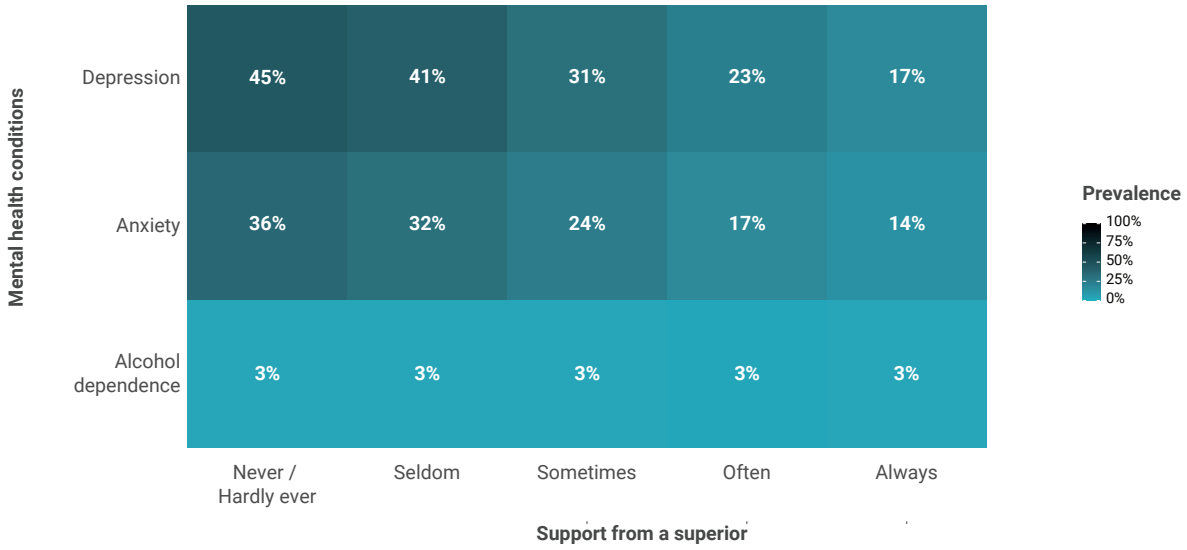


Figure 44. Prevalence of probable mental health conditions, by perceived frequency of support from superiors



Greater control over work is linked with better mental health

Control over one's work was measured by asking participants to what extent they could influence their tasks and whether they could decide when to take breaks. The degree of influence is low overall, and lower for nurses than for doctors, with 53% of doctors reporting having influence over their work, compared to 43% of nurses.

There is an inverse relationship between control over work and mental health difficulties: greater perceived control or influence was associated with better mental health (Fig. 45 and 46).

Figure 45. Prevalence of mental health conditions, by degree of influence over work

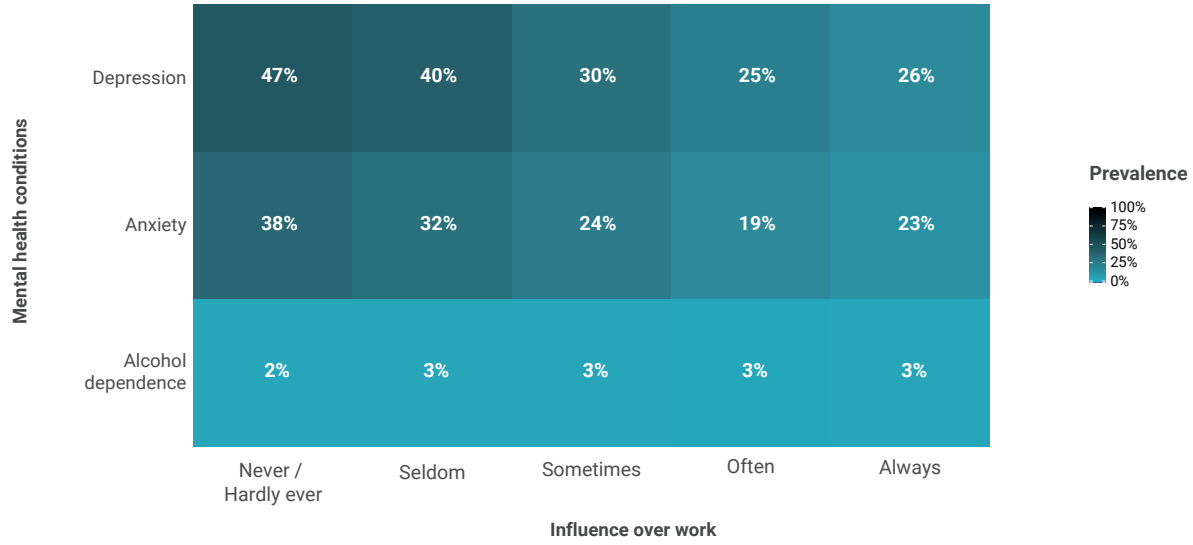
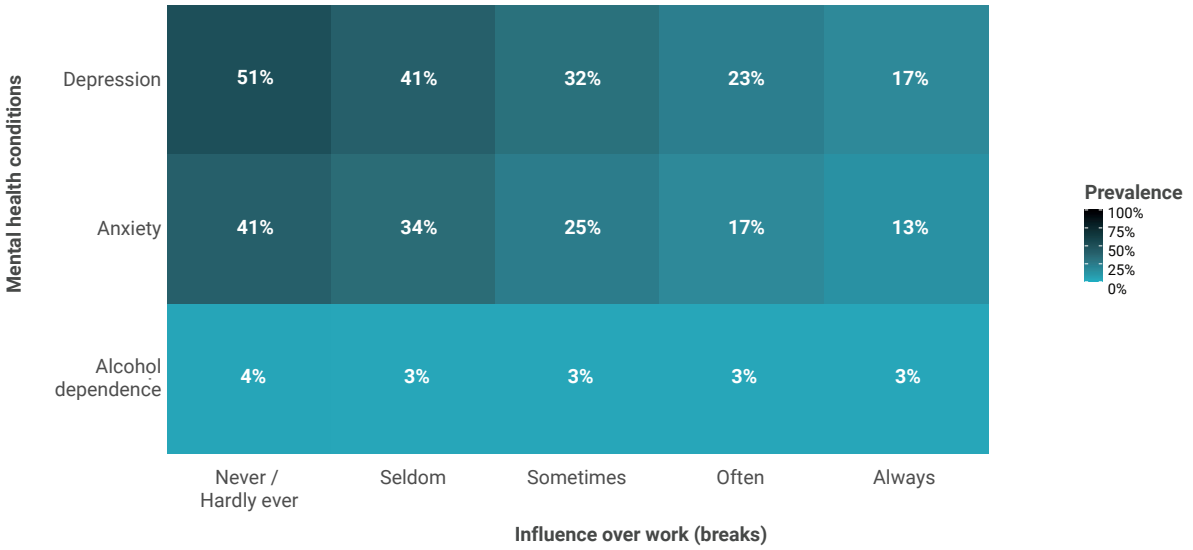


Figure 46. Prevalence of mental health conditions, by degree of control over timing of breaks

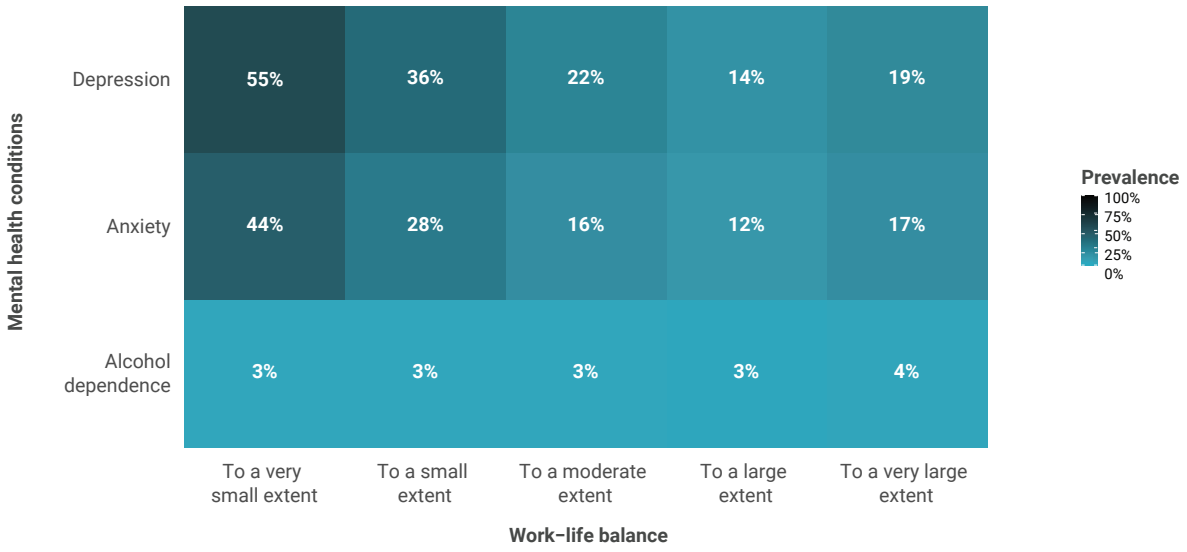


Overall, survey respondents reported low levels of work–life balance, with one in four doctors and one in five nurses describing their work as enabling a work–life balance (Fig. 47). As expected, better work–life balance is associated with better mental health, with a more than 50% decrease in the prevalence of anxiety and depression amongst workers reporting the highest work–life balance compared to those reporting the lowest (Fig. 48).

Figure 47. Proportion of people reporting work–life balance, by profession and gender

Work–life balance	Female	Male	Overall
DOCTORS	22%	27%	24%
NURSES	20%	16%	20%

Figure 48. Prevalence of mental health conditions, by perceived work–life balance

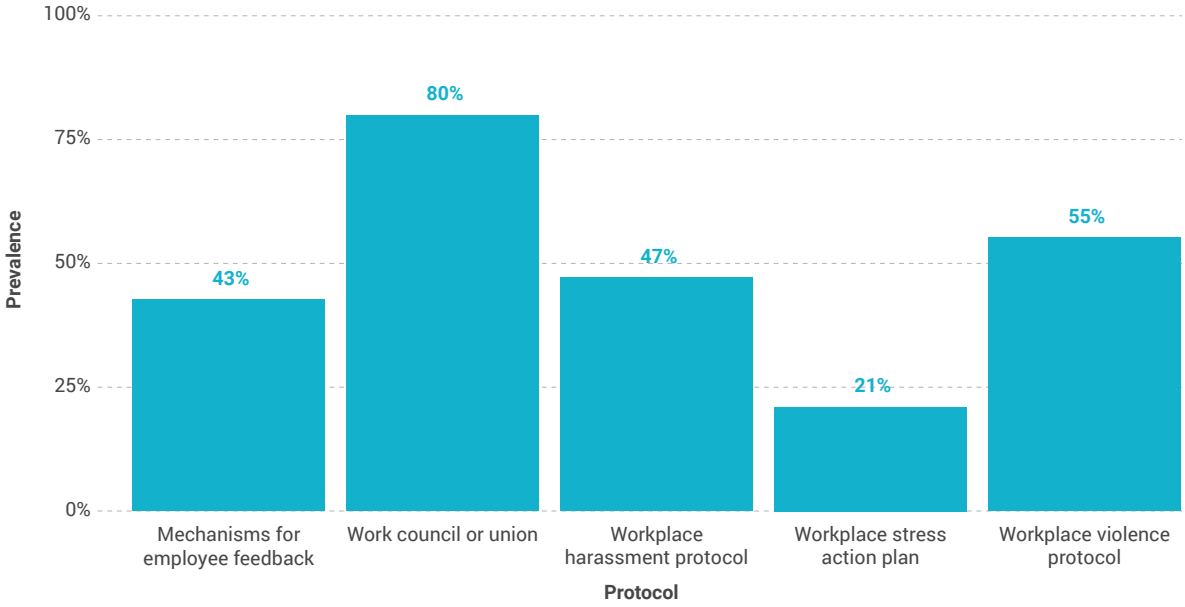


Workplace support structures

In the MeND survey, respondents were asked whether a range of workplace support structures were available to them. The findings show that only half of respondents reported having protocols in place for harassment and violence, and fewer than 25% reported having a stress action plan (Fig. 49).

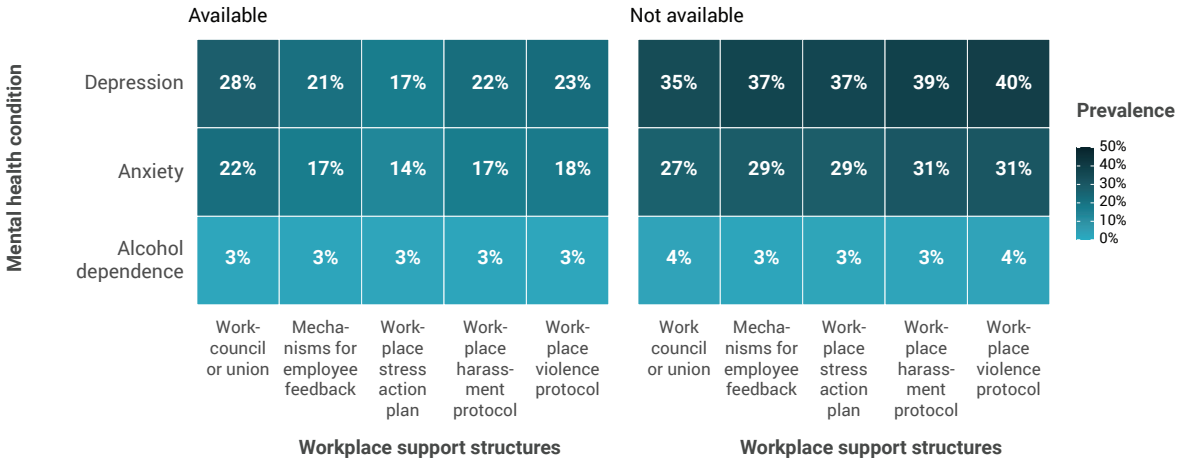
Workplace support structures have a positive association with mental health

Figure 49. Proportion of available workplace support structures, as reported by workers



Where protocols exist, however, there is positive impact. Health workers reporting the presence of workplace support structures were less likely to report mental health difficulties (Fig. 50). Existence of organizational psychosocial safety protocols had the strongest relationship, with an almost halving of the prevalence of anxiety and depression among those reporting that protocols to address violence, harassment and stress were present in their workplace.

Figure 50. Prevalence of mental health conditions, by reported availability of workplace support structures

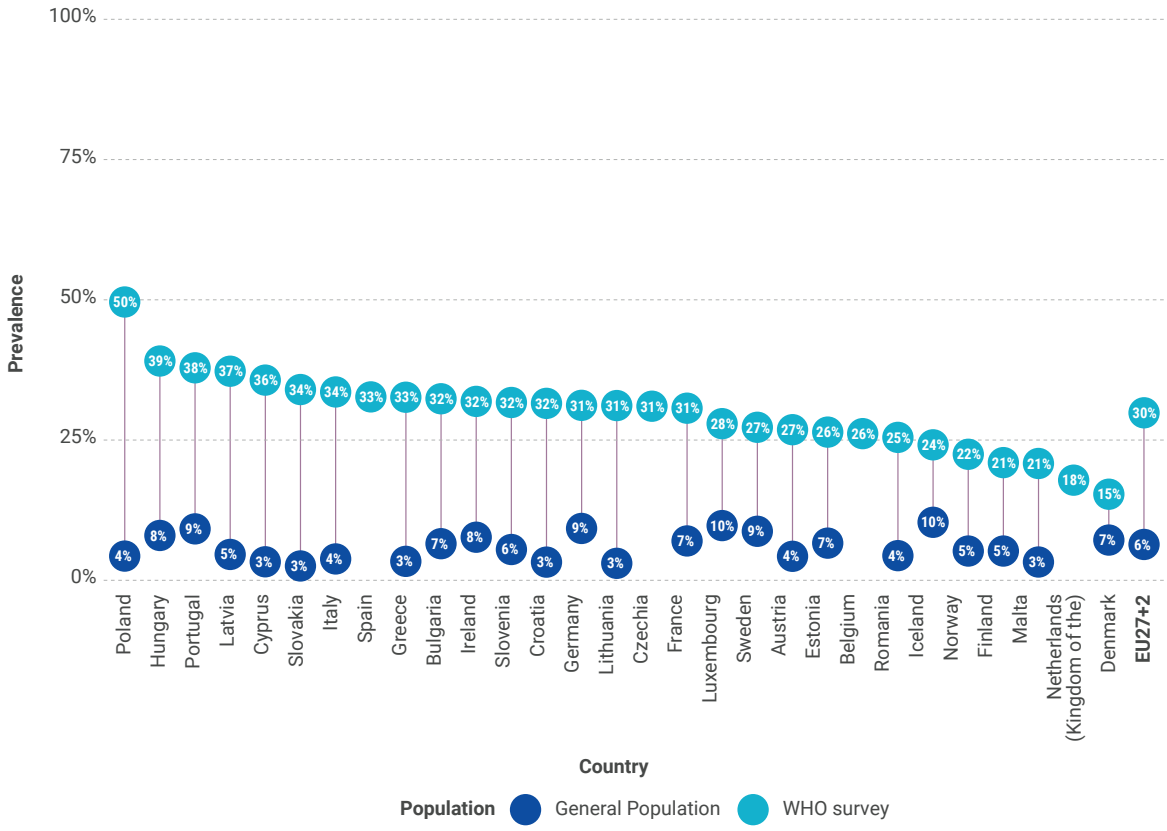


Discussion and implications

Mental health difficulties

Our findings reveal that nurses and doctors experience both high rates of mental health difficulties and unfavourable working conditions that negatively impact their mental health and well-being. The average prevalence of probable major depressive disorder is 30% in the sample, which suggests a five-fold higher rate compared to estimates in the general population from the European Health Interview Survey conducted between 2013 and 2015 using the same instrument *(24)* (Fig. 51). The rates are consistently higher in every country than the rates found in the general population, but the variation between countries does not follow the same trend. For example, Poland has the highest prevalence of depression in the sample, but one of the lowest in the general population. Of note, rates of anxiety and depression are similar to or higher than those found during the COVID-19 pandemic in Europe *(25,26)* and globally *(7, 27–30)*.

Figure 51. Prevalence of probable major depressive disorders across countries, compared to the general population



Note: Reference data were drawn from Arias-de la Torre et al. *(24)*. Prevalence estimates were based on the 8-item Patient Health Questionnaire (PHQ-8) to ensure comparability between the two studies. The proportion of responses to the MeND survey is below 1% in Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland.

A critical finding is that more than one in 10 doctors and nurses report experiencing suicidal thoughts or thoughts of harming themselves. This is more than double the prevalence of suicidal ideation previously reported in the general population[4] *(31)*. It is also in line with findings from the United States of America,

4 Pooled point prevalence from a meta-analysis of 12 studies in European samples. Suicidal ideation was defined as thoughts of suicide without planning or attempt.

showing that registered nurses – but not physicians – were 64% more likely to die by suicide than other professionals *(6)*. Importantly, it highlights a problem that exists already during postgraduate training *(32)* and even in medical schools *(33)*.

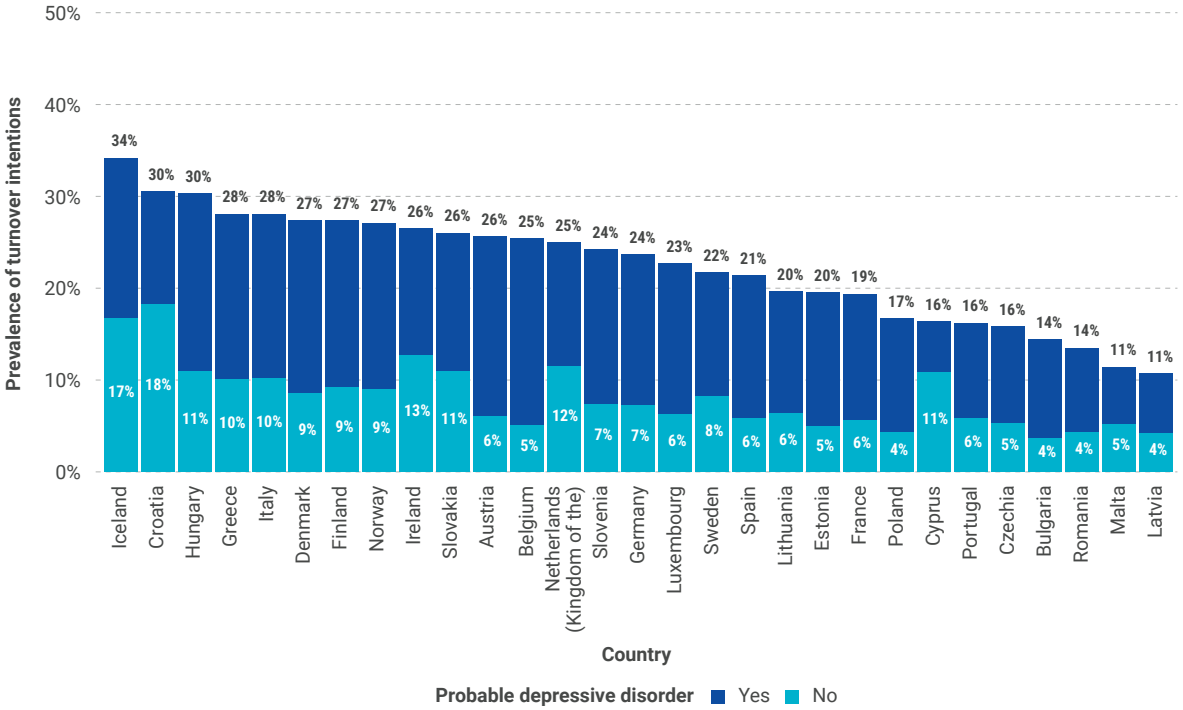
Working conditions create risks for mental health and well-being

Doctors and nurses exposed to certain working conditions, including violence, are more likely to report mental health difficulties. Prevalence of depression was 48% among workers exposed to bullying compared to 22% among those not exposed. Similarly, depression prevalence showed a 1.75 times higher rate (from 28% to 49%) for those reporting sexual harassment, compared to those who did not. Structural factors, such as temporary employment, also seemed to influence depression prevalence rates, which were five percentage points higher among those with temporary contracts. A 10-percentage point difference was found with respect to extended working hours: the prevalence of depression was at 29% among those working less than 50 hours per week and at 39% among those working over 50 hours. This is in line with previous findings, showing that some working conditions are associated with later development of depressive disorders, including exposure to job strain, violence, job demands or job insecurity *(34)*.

Mental health problems impact healthcare systems

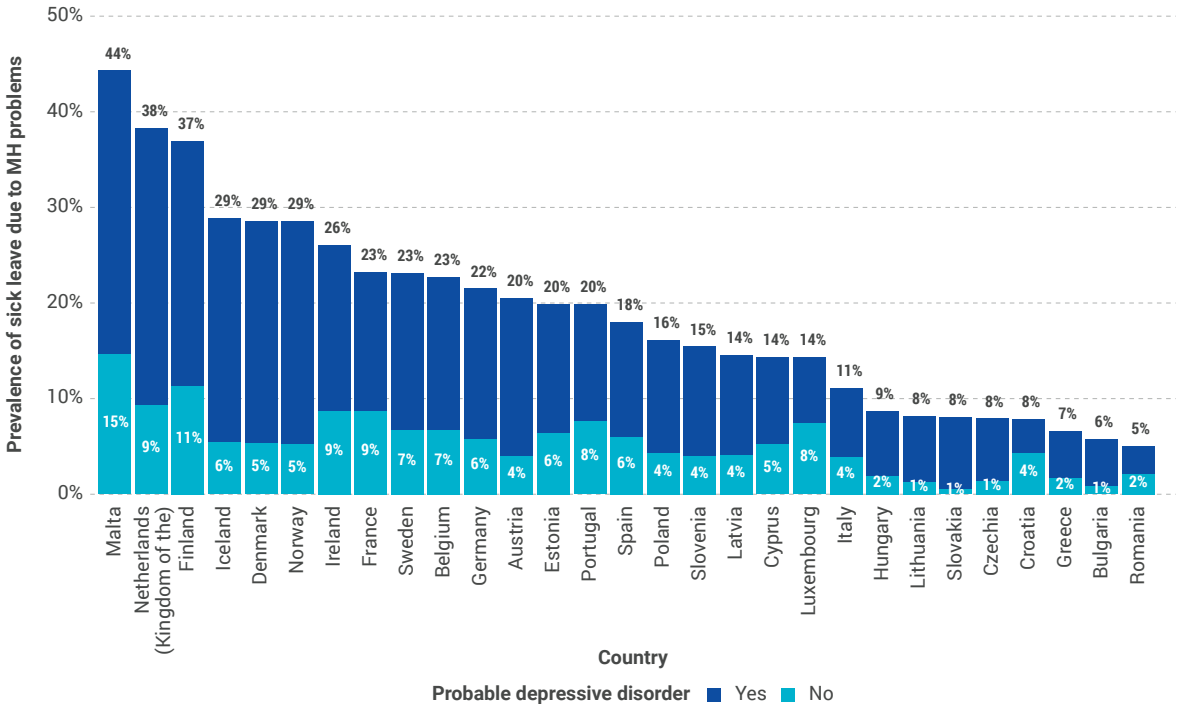
Our findings also show that doctors and nurses who report mental health problems are more likely to report an intention to leave their job or to take sick leave (see Fig. 52 and 53). This is not surprising, considering that depressive disorders are the second leading cause of years lived with disability worldwide, accounting for an estimated loss of 56 million years lived with disability *(29,30)*.

Figure 52. Prevalence of intention to leave among workers with and without probable major depressive disorder, by country



Note: Prevalence estimates were based on the 9-item Patient Health Questionnaire (PHQ-9). The proportion of responses to the MeND survey is below 1% in Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland.

Figure 53. Prevalence of sick leave due to mental health problems among workers with and without probable major depressive disorder, by country

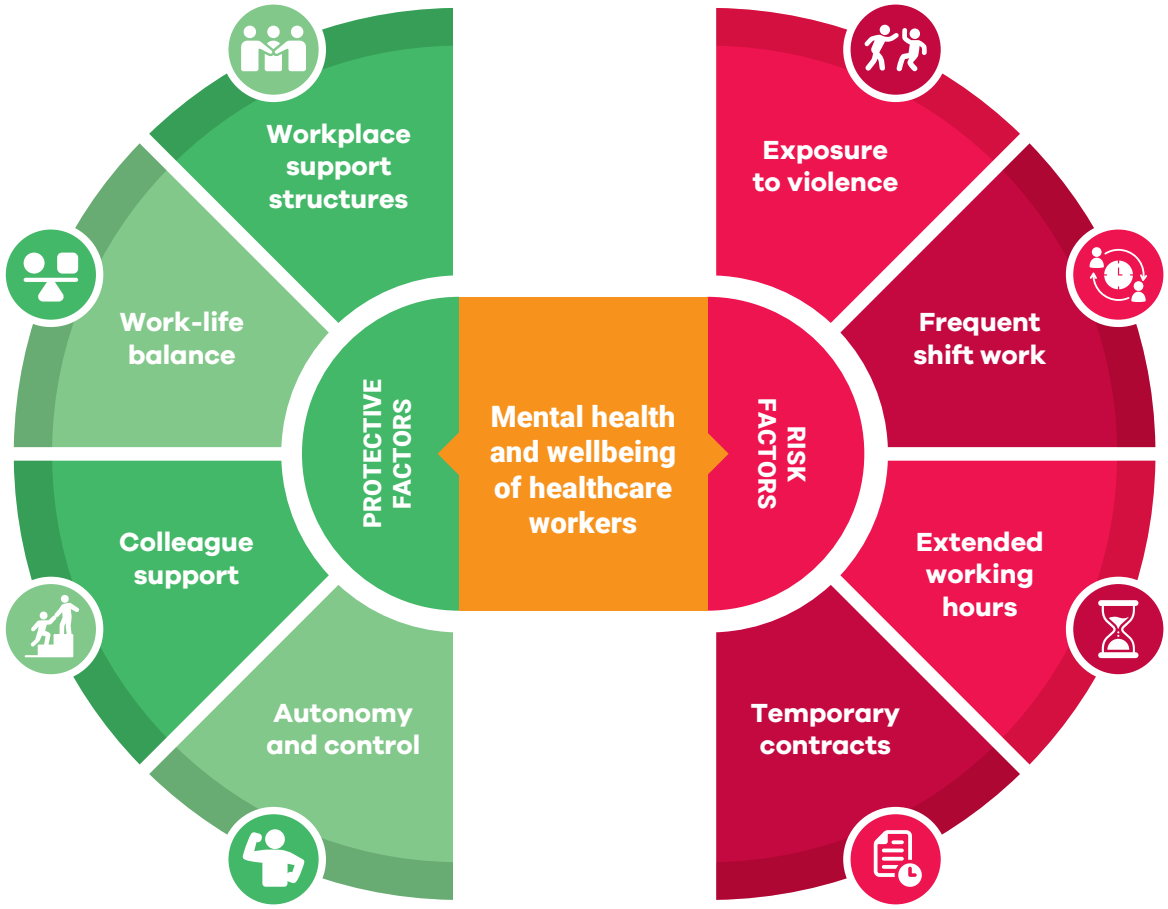


Note: Prevalence estimates were based on the 9-item Patient Health Questionnaire (PHQ-9). The proportion of responses to the MeND survey is below 1% in Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland.

Opportunities for mental health promotion and protection

The connection between working conditions and mental health outcomes poses both a challenge and an opportunity for healthcare systems, highlighting both risk and protective factors that can be leveraged to better protect mental health and well-being (Fig. 55). Many of the working conditions negatively impacting mental health and well-being can be reduced or eliminated, such as exposure to violence and temporary contracts, while protective factors can be actioned – with our findings showing that social support, autonomy and control, and workplace support structures are associated with positive mental health and well-being. For example, the prevalence of depression and anxiety is nearly 50% lower among those with access to protocols to manage violence or harassment in the workplace than among those without. Similarly, anxiety is almost three times lower among those who perceived their workplace as enabling optimal work–life balance, compared to those reporting the lowest levels of work–life balance support.

Figure 54. A diagram illustrating the workplace-related risk and protective factors found to be associated with mental health and well-being outcomes of healthcare workers



Note: Risk and protective factors are not exhaustive, and are based on exposures measured through this MeND survey.

Limitations

It is important to acknowledge some limitations of the survey. First, probabilistic sampling was not feasible and accurate response rates could not be calculated. This increases the risk of self-selection bias – both among those who received the survey invitation and those who chose to participate. Second, all data were collected through self-report measures. While these instruments use thresholds that have been validated across most EU countries, they do not allow for clinical diagnosis and may overestimate the prevalence of certain mental health conditions. Finally, the survey employed a cross-sectional design, capturing data at a single point in time. This limits the ability to draw conclusions about causality and raises the possibility of reverse causation in observed associations between stressors and mental health outcomes.

A call for action

Mental health problems are highly prevalent among doctors and nurses in Europe: One in three doctors and nurses in the 29 participating countries report symptoms consistent with anxiety and depressive disorders, with prevalence rates ranging across countries from 10% to over 50% for anxiety and depression. Three percent report signs of probable alcohol dependence. One in ten report suicidal thoughts or thoughts of harming themselves. Working conditions are challenging, with half of all doctors and nurses reporting exposure to violence at their workplace. Access to supports and protective structures – at the individual, interpersonal, and organizational levels – is far from universal.

We cannot go on with business as usual. There is a clear and consistent association between better working conditions and better mental health across countries. Addressing both the risk and protective factors to shape environments that enable optimal mental health and well-being for all health and care workers is urgently needed. Protecting and promoting health and care workers' mental health and working conditions will not only improve their well-being but also contribute to strengthening overall healthcare provision through the expected reduction in sick leave and turnover.

Based on the findings, and in line with and in line with prevailing frameworks and guidelines[5], this report proposes seven policy actions. Taken together these will prevent mental ill health, protect and promote mental health and well-being and create the enabling environments necessary to improve retention and attraction of health and care workers and ultimately contribute to reversing the health workforce crisis facing health care systems.

1. **Enforce a zero-tolerance approach to bullying, harassment, and other forms of workplace violence.** This needs to be accompanied by strategies to develop, improve and promote awareness of organizational and legislative support structures, such as better incident reporting systems. Strategies should aim to enable long-term monitoring and identification of risks and improve attitudes toward health and care workers.
2. **Improve predictability and flexibility related to shift work.** To address the mental health risks associated with shift work, organizations can aim to reduce the unpredictability and inflexibility of working hours, giving workers greater control over their scheduling where possible. Promotion and prevention can also be achieved through limiting consecutive night shifts, limiting long shifts, promoting adequate rest, and enhancement of other protective factors, including social support, influence over work and workplace support structures.
3. **Manage overtime in line with health workers' needs and entitlements while reimagining workplace norms and culture.** International and European standards for working hours should be promoted and enforced by countries through legislative and policy actions. Organizational mechanisms should be employed to facilitate monitoring of overtime and compensation for time worked, with the aim of discouraging cultures where overtime is encouraged or expected *(3)*.
4. **Manage excessive workload to deliver quality health services, by focusing on improving staffing approaches and optimizing workflows** through the reorganization of services, the adaptation of the skill mix, the use of digital health technologies and the streamlining of administrative tasks.
5. **Build the capacity and accountability of healthcare leaders and managers to promote and protect staff mental health and well-being, making protection of staff mental health a key performance measure.** Managers and leaders are essential for operationalizing key protective factors identified in the findings, including fostering support from colleagues, increasing autonomy of staff, and ensuring the presence of support and feedback mechanisms.
6. **Make mental health and substance use support available and accessible to all workers to facilitate early intervention.** Supports must be confidential, able to be utilised without fear of repercussions, and aligned with the needs and preferences of staff. In addition to providing support to workers who are experiencing mental health problems, support should be available for those returning to work after sick leave and facilitated through promoting care pathways and addressing barriers to seeking care, such as stigma related to mental health and substance use.

5 WHO European Frameworks for action on Mental Health *(12) (6)* and the Health and Care Workforce *(13) (39)*, the WHO guidelines on mental health at work *(35) (8)*, the WHO Duty of Care Report *(36) (9)*, and the UN Employment Conditions Framework *(37) (10)*.

7. **Prioritize regular assessment and reporting of mental health and working conditions.** Countries are encouraged to monitor mental health and working conditions at the local, regional and national levels. Such regular assessments can help build accountability, facilitate dialog between stakeholders and identify solutions, while monitoring progress.

Implementing these policy actions should be the result of a collaboration between stakeholders at the local, regional and national levels, including policy-makers, healthcare organizations, municipal governments, professional associations and unions. These actions are proposals to be adapted and implemented in concert with healthcare professionals at every stage, supported by strong mechanisms for monitoring and accountability for implementation.

Implementation must also consider the structural and demographic differences between doctors and nurses, including key determinants such as gender and socioeconomic status. An intersectional approach - recognizing how these factors interact to shape vulnerability - should be used to identify the most at-risk groups and prioritize targeted, equitable policies.

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Annex 1: Methodology

Survey design

The Mental Health of Nurses and Doctors (MeND) survey is an online instrument comprising 76 items. It covers four areas: sociodemographic characteristics, working conditions, mental health outcomes (anxiety, depression and drinking problems) and well-being. Most items were obtained directly from different data sources, including Eurostat, the European Parliament, European Working Conditions Telephone Survey (EWCTS 2021) and the European Survey of Enterprises on New and Emerging Risks 2019, as well as validated psychosocial and mental health questionnaires (see Instruments). Some items were developed ad hoc within the survey working group with inputs from professional medical and nursing associations.

The survey platform was available in 25 languages for the 29 countries. Items developed ad hoc were translated from English by one translator and revised by one reviewer for each language (i.e., back-translation). Translations of items included in available surveys and questionnaires were only performed if instrument translations were not available.

The study protocol was developed by the WHO Regional Office for Europe in collaboration with the WHO Collaborating Centre for Mental Health Services Research and Training, based at the Universidad Autónoma de Madrid in Spain. The study was given ethical approval by the Ethics Committee at the Universidad Autónoma de Madrid (identifier: CEI-141-3158).

Mental health and workplace questionnaires

- **Nine-item Patient Health Questionnaire (PHQ-9)**. The PHQ-9 is a self-report measure used to assess the severity of depressive symptoms based on the criteria set forth in the *Diagnostic and Statistical Manual of Mental Disorders (fourth edition)*. Respondents rate how often they have been bothered by each of the nine symptoms over the past two weeks using a four-point scale ranging from "not at all" to "nearly every day". Each item is scored from 0 to 3, resulting in a total score range of 0 to 27, with higher scores indicating greater levels of depressive symptoms. Scores equal to or higher than 10 points are used to identify people with probable major depressive disorders. Cut-off scores used to identify probable major depressive disorders vary across countries, typically ranging from 8 to 12, with 10 being the most common.

  A single item of the PHQ-9 was used to measure suicidal thoughts. Respondents rate how often over the past two weeks they have been bothered by 'thoughts that (they) would be better off dead or of hurting (themself) in some way'

- **Seven-item Generalized Anxiety Disorder scale (GAD-7).** The GAD-7 is a self-report instrument designed to screen for and assess the severity of generalized anxiety disorder symptoms. Respondents indicate how often they have experienced each symptom over the past two weeks on a four-point scale, from "not at all" to "nearly every day". Items are scored from 0 to 3, producing a total score ranging from 0 to 21, with higher scores reflecting more severe anxiety symptoms. Cut-off scores used to identify probable anxiety disorders vary across countries, typically ranging from 5 to 12, with 10 being the most common.
- **World Health Organization-Five Well-Being Index (WHO-5).** The WHO-5 is a brief self-report measure of current mental well-being. Respondents are asked to rate how often they have experienced five positive feelings over the past two weeks, using a 6-point scale ranging from "at no time" to "all of the time". Each item is scored from 0 to 5, yielding a total raw score between 0 and 25, which can be multiplied by 4 to create a percentage score from 0 to 100, with higher scores indicating greater well-being. A cut-off of 50 points is frequently used to detect people with lowered well-being levels.
- **"Cut down, Annoyed, Guilty and Eye-opener" questionnaire (CAGE).** The CAGE is a four-item self-report screening tool designed to identify potential problems with alcohol use. It consists of yes/no questions addressing attempts to cut down, annoyance by criticism, guilty feelings and use of alcohol as an eye-opener. Each "yes" response scores 1 point, with a total score ranging from 0 to 4. A cut-off score of 2 or more is typically used to indicate clinically significant alcohol use and the need for further assessment.
- **Copenhagen Psychosocial Questionnaire II (COPSOQ-II).** The COPSOQ-II is a comprehensive self-report instrument designed to assess a wide range of psychosocial factors in the workplace. It includes multiple scales covering domains such as demands at work, work organization and job content, interpersonal relations and leadership and work–life balance. Respondents rate items on Likert-type scales, typically ranging from 0 to 4 or 1 to 5, depending on the version used. The COPSOQ-II is intended to support workplace risk assessments and interventions, with higher or lower scores on specific scales indicating areas of potential concern or strength in the psychosocial work environment. A selection of items was included in the MeND survey.
- **The Work and Meaning Inventory.** The Work and Meaning Inventory is a self-report measure that assesses the extent to which people find meaning and purpose in their work. It includes items evaluating meaningfulness, the sense of greater good and the impact of work on personal growth. Respondents rate statements on a Likert scale, with higher scores indicating a stronger experience of meaningful work. Two items were included in the MeND survey.

Variables

In this report, several items used in the survey for analysis were transformed. Most transformations consisted of dichotomizing Likert-type responses to individual items and summed questionnaire scores. An overview of this process is provided in Table A1.1.

Table A1.1. Overview of study variables and applied transformations

Domain	Item	Levels	Dichotomization
Sociodemo-graphics	Gender	Male, female, other	Only people self-identifying as male and females were included in disaggregated analyses for methodological reasons.
	Age group	Groups comprising 5 years each, except for less than 20 or over 70 (e.g., 20–25, 36–30, etc.)	Not applicable.
	Profession	Doctor, nurse	Not applicable.
Working hours and contracts	Usual weekly working hours	10-hour blocks covering from less than 10 hours to more than 60 hours (e.g., 11–20, 21–30, etc.)	Extended working hours are defined as people working more than 50 hours per week.
	Night shifts frequency	Ordinal relative frequency, from "never/rarely (e.g., once or twice a year)" to "every day".	Working nights almost every week and more frequently is considered as frequent night shifts.
	Regular shift work	Binary: yes, no.	Not applicable.
	Type of contract	Fixed, temporary	Not applicable.
Exposure to violence	Bullying	"No", and an ordinal scale for positive responses in time dimension: "Yes,…", with one of the following: "…daily", "…weekly", "…monthly", "…a few times".	As this is considered critical, any positive response, regardless of periodicity was considered as having been exposed to violence.
	Harassment		
	Violent threats		
	Physical violence		
	Managing patient and relative anger	Ordinary scale with time dimension responses (e.g., "never", "around ¼ of the time", "almost all of the time").	Also considered critical due to the impact on HCWs mental health and well-being, only "never" and "almost never" were considered negative answers, the rest were collapsed as a positive answer.

Table A1.1. Overview of study variables and applied transformations (cont.)

Domain	Item	Levels	Dichotomization
Social support and control	Support from colleagues	Ordinary scale with time dimension responses (e.g., "never/hardly ever", "seldom", "often").	If "often" or "always" were reported, the participant was classified as perceiving support and control.
	Support from superiors		
	Influence over work		
	Influence over work (breaks)		
	Work-life balance	Subjective ordinary scale, with responses comprising "to a very small extent" to "to a very large extent", with 3 intermediate levels.	When reporting the options "to a large extent" or "to a very large extent", a perceived work-life balance was considered.
Workplace support structures	Work council or union	Yes, no, and "I don't know".	"I don't know" responses were recoded as missing.
	Mechanisms for employee feedback		
	Workplace harassment protocol		
	Workplace stress action plan		
	Workplace violence protocol		
Mental health outcomes	Depressive symptoms	The 9 items of the PHQ-9 were used to compute a sum score (from 0 to 27)	Validated cut-offs (varying between country-specific contexts: 8-12. Standard: 10) were used across countries to estimate the prevalence of depressive symptoms compatible with major depressive disorders
	Anxiety symptoms	The 7 items of the GAD-7 were used to compute a sum score (from 0 to 21)	Validated cut-offs (scores varying between country-specific contexts: 5-12. Standard threshold score: 10) were used across countries to estimate the prevalence of anxiety symptoms compatible with anxiety disorders.
	Alcohol dependence	The 4 items of the CAGE questionnaire were used to compute a sum score (from 0 to 4)	Respondents with sum scores of 2 or more were classified as having probable alcohol dependence.
	Suicide thoughts	The 9th item of the PHQ-9 was used to estimate suicide thoughts	Respondents with any positive response (score > 0) in this item were classified as having suicide thoughts, based on studies that have associated this with increased risk of attempting or completing suicide.

Table A1.1. Overview of study variables and applied transformations (cont.)

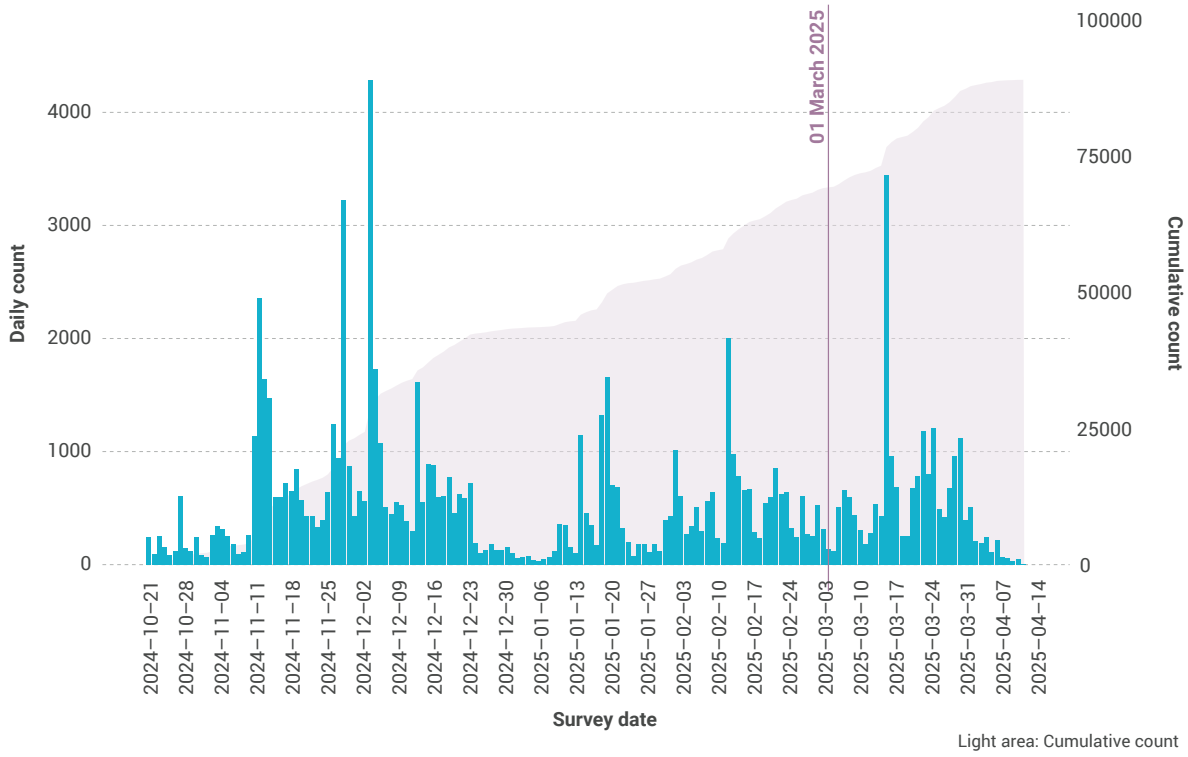
Domain	Item	Levels	Dichotomization
Well-being	Emotional well-being	The 5 items of the WHO-5 Well-Being Index were used to compute a raw sum score (from 0 to 25), which must be multiplied by 4 to get the total score (0 to 100).	A validated cut-off (score > 50) was used across countries to estimate the prevalence of self-reported emotional well-being.
	Meaning and purpose at the workplace	Two items from the Work and Meaning Inventory were used, with scores from 0 to 4, being higher scores compatible with better agreement with the statements.	Positive answers ("mostly true" or "absolutely true", corresponding to scores of 3 or 4 on a 0–4 scale) were classified in each item as indicating that participants found their career meaningful and believed their work serves a greater purpose.
	Job satisfaction	A quantitative subjective scale was provided: "highly unsatisfied" as the lowest, and "very satisfied" as the highest levels.	Dichotomized to a positive answer if any "satisfied" option was chosen, and the opposite when selecting options containing "unsatisfied".

CAGE = "Cut down, Annoyed, Guilty and Eye-opener" questionnaire, GAD-7 = seven-item Generalized Anxiety-Disorder scale, PHQ-9 = nine-item Patient Health Questionnaire, WHO-5 = World Health Organization-5 Well-being Index

Sampling method

Respondents were recruited through non-probabilistic sampling methods. Up until 28 February 2025, recruiting agents were six European medical and nursing associations (European Junior Doctors Association, Standing Committee of European Doctors, European Union of General Practitioners, European Union of Medical Specialists, European Federation of Nurses Associations and European Forum of National Nursing and Midwifery Associations). These associations contacted their members in the participating countries (i.e., national associations) and asked them to share the survey link with their members – doctors or nurses. This sampling strategy provided most of the survey sample. In a final stage, the link to the survey was distributed via the social media channels of the WHO Regional Office for Europe and the European and national associations (Fig. A1.1).

Figure A1.1. Absolute (bars) and cumulative (area) number of responses, by date



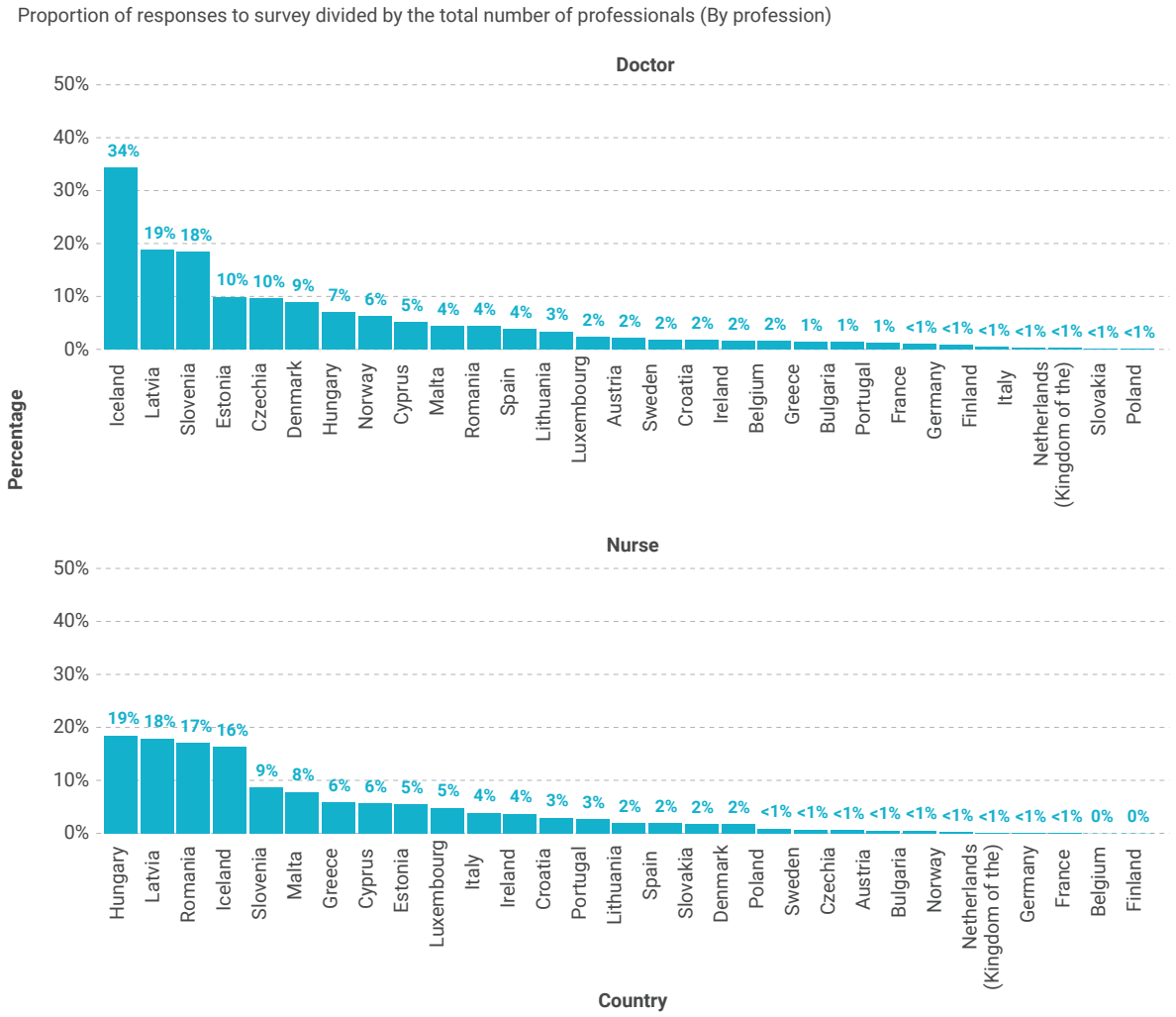
Note: The blue line shows the date when recruitment via social media started (1 March 2025).

In the invitation and on the welcome page, potential respondents were asked to fill in the survey if they were doctors or nurses who were currently working. To prevent duplicates, they were also asked to avoid completing it twice.

It was not possible to determine how many potential respondents received the survey link to estimate response rates. Instead, the total number of doctors and nurses was used to estimate the proportion of respondents by country. This means that while the survey did not reach all doctors and nurses in every country, the total numbers of doctors and nurses were used as denominators. The denominators were obtained from the WHO National Health Workforce Accounts tool (*1*).

The proportion of responses was similar for doctors and nurses across countries (Fig. A1.2). Estonia, Hungary, Iceland, Latvia and Slovenia had the highest proportion of responses, while Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland had responses below 1%. A caption is included in all plots showing results by country with a call for cautious interpretation of the results in these countries.

Figure A1.2. Proportion of responses, by profession and country


Proportion of responses to survey divided by the total number of professionals (By profession)
Doctor
Percentage
50%
40%
30%
20%
10%
0%
34% 19% 18% 10% 10% 9% 7% 6% 5% 4% 4% 4% 3% 2% 2% 2% 2% 2% 2% 1% 1% 1% <1% <1% <1% <1% <1% <1% <1%
Iceland Latvia Slovenia Estonia Czechia Denmark Hungary Norway Cyprus Malta Romania Spain Lithuania Luxembourg Austria Sweden Croatia Ireland Belgium Greece Bulgaria Portugal France Germany Finland Italy Netherlands (Kingdom of the) Slovakia Poland
Nurse
50%
40%
30%
20%
10%
0%
19% 18% 17% 16% 9% 8% 6% 6% 5% 5% 4% 4% 3% 3% 2% 2% 2% 2% <1% <1% <1% <1% <1% <1% <1% <1% <1% 0% 0%
Hungary Latvia Romania Iceland Slovenia Malta Greece Cyprus Estonia Luxembourg Italy Ireland Croatia Portugal Lithuania Spain Slovakia Denmark Poland Sweden Czechia Austria Bulgaria Norway Netherlands (Kingdom of the) Germany France Belgium Finland
Country

Note: Reference data are drawn from the WHO Regional Office for Europe, OECD and Eurostat joint questionnaire on non-monetary healthcare statistics (data not available for nurses in Belgium and Finland). The proportions for nursing in Belgium and Finland cannot be calculated due to unavailability of population data.

Sample characteristics

There were a total of 122 048 participants. After invalid observations were removed, the final number of valid responses was 90 171 (78% of the total responses), comprising 37 864 doctors and 52 307 nurses. The number of fully completed surveys was 75 737 (84% of the valid responses), with a median time of 9.8 minutes. The distribution of responses by profession, gender and country is presented in Table A1.2.

Table A1.2. Number of valid responses by country, stratified by profession and gender

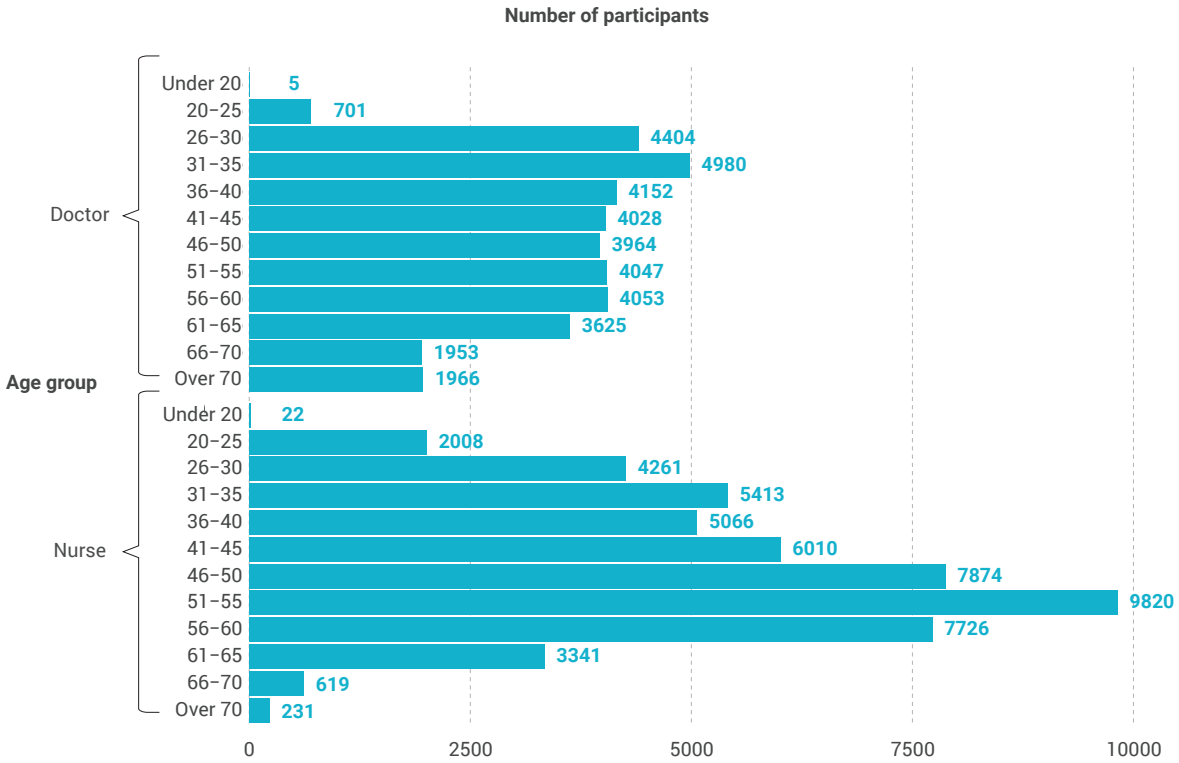
	Doctors			Nurses		
Characteristic	Female N = 25 453[1]	Male N = 12 347[1]	Other N = 64[1]	Female N = 45 384[1]	Male N = 6 880[1]	Other N = 43[1]
Country						
Austria	624 (58%)	445 (41%)	4 (0.4%)	430 (83%)	87 (17%)	0 (0%)
Belgium	403 (64%)	222 (35%)	1 (0.2%)	532 (82%)	117 (18%)	2 (0.3%)
Bulgaria	261 (64%)	144 (35%)	1 (0.2%)	140 (96%)	6 (4.1%)	0 (0%)
Croatia	193 (74%)	66 (25%)	1 (0.4%)	247 (91%)	24 (8.9%)	0 (0%)
Cyprus	132 (55%)	109 (45%)	0 (0%)	216 (79%)	58 (21%)	0 (0%)
Czechia	2 987 (67%)	1 491 (33%)	7 (0.2%)	452 (91%)	46 (9.2%)	0 (0%)
Denmark	1 468 (62%)	886 (38%)	2 (<0.1%)	997 (96%)	42 (4.0%)	1 (<0.1%)
Estonia	380 (82%)	84 (18%)	0 (0%)	475 (98%)	12 (2.5%)	0 (0%)
Finland	83 (73%)	30 (26%)	1 (0.9%)	2 009 (95%)	101 (4.8%)	6 (0.3%)
France	1 492 (69%)	661 (31%)	5 (0.2%)	379 (83%)	79 (17%)	0 (0%)
Germany	2 238 (68%)	1 040 (32%)	3 (<0.1%)	614 (78%)	174 (22%)	2 (0.3%)
Greece	533 (54%)	444 (45%)	2 (0.2%)	1 136 (84%)	219 (16%)	0 (0%)
Hungary	1 568 (67%)	764 (33%)	1 (<0.1%)	7 158 (92%)	627 (8.1%)	3 (<0.1%)
Iceland	255 (53%)	225 (47%)	1 (0.2%)	542 (96%)	23 (4.1%)	0 (0%)
Ireland	189 (58%)	136 (41%)	3 (0.9%)	2 495 (92%)	213 (7.9%)	1 (<0.1%)
Italy	466 (57%)	350 (43%)	0 (0%)	11 793 (79%)	3 095 (21%)	10 (<0.1%)
Latvia	976 (82%)	220 (18%)	1 (<0.1%)	1 390 (99%)	13 (0.9%)	1 (<0.1%)
Lithuania	337 (80%)	85 (20%)	0 (0%)	401 (98%)	6 (1.5%)	1 (0.2%)
Luxembourg	22 (55%)	18 (45%)	0 (0%)	264 (78%)	73 (22%)	1 (0.3%)
Malta	52 (50%)	52 (50%)	0 (0%)	219 (68%)	102 (32%)	0 (0%)
Netherlands (Kingdom of the)	152 (74%)	53 (26%)	0 (0%)	159 (88%)	22 (12%)	0 (0%)
Norway	1 005 (57%)	742 (42%)	2 (0.1%)	176 (89%)	21 (11%)	0 (0%)
Poland	53 (58%)	35 (38%)	3 (3.3%)	1 871 (94%)	119 (6.0%)	1 (<0.1%)
Portugal	568 (76%)	182 (24%)	0 (0%)	1 778 (85%)	300 (14%)	2 (<0.1%)

Characteristic	Doctors			Nurses		
	Female N = 25 453[1]	Male N = 12 347[1]	Other N = 64[1]	Female N = 45 384[1]	Male N = 6 880[1]	Other N = 43[1]
Romania	2 218 (74%)	783 (26%)	2 (<0.1%)	778 (92%)	254 (8.4%)	0 (0%)
Slovakia	12 (41%)	17 (59%)	0 (0%)	517 (93%)	36 (6.5%)	0 (0%)
Slovenia	976 (74%)	337 (26%)	3 (0.2%)	815 (91%)	80 (8.9%)	1 (0.1%)
Spain	5 201 (67%)	2 508 (32%)	20 (0.3%)	4 653 (84%)	854 (15%)	11 (0.2%)
Sweden	596 (74%)	207 (26%)	1 (0.1%)	717 (90%)	77 (9.7%)	0 (0%)
Unknown	13	11	0	31	0	0

[1] **n (%)**

Doctors and nurses of all ages were represented in the survey. The age distribution was flatter for doctors (almost the same number of respondents between 26 and 65 years of age) than for nurses (most respondents were 46 to 60 years of age) (Fig. A1.3).

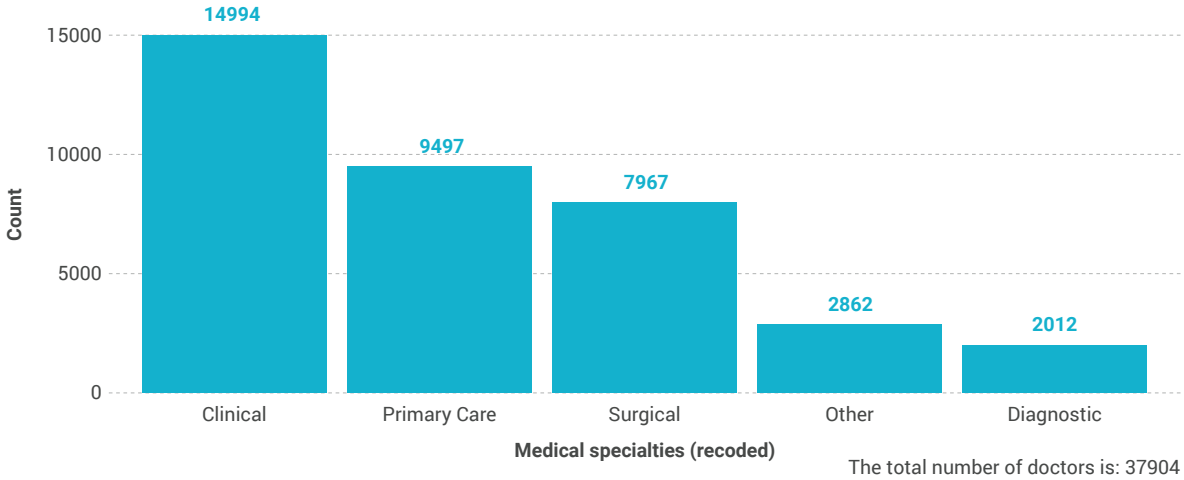
Figure A1.3. Age distribution, by profession



Two thirds of respondents worked exclusively for the public healthcare sector and four out of five provided clinical care to patients – the rest were managers, administrative staff or researchers. Most respondents worked in hospital services (n = 39 719; 44%) and in primary care (n = 21 747; 24%). Most doctors had clinical medical specialties, followed by primary care and surgical specialties (Fig. A1.4).[7]

7 Medical specialties were obtained from Commission Delegated Decision (EU) 2019/608 of 16 January 2019 amending Annex V to Directive 2005/36/EC of the European Parliament and of the Council as regards the evidence of formal qualifications and titles of training courses (https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32019D0608).

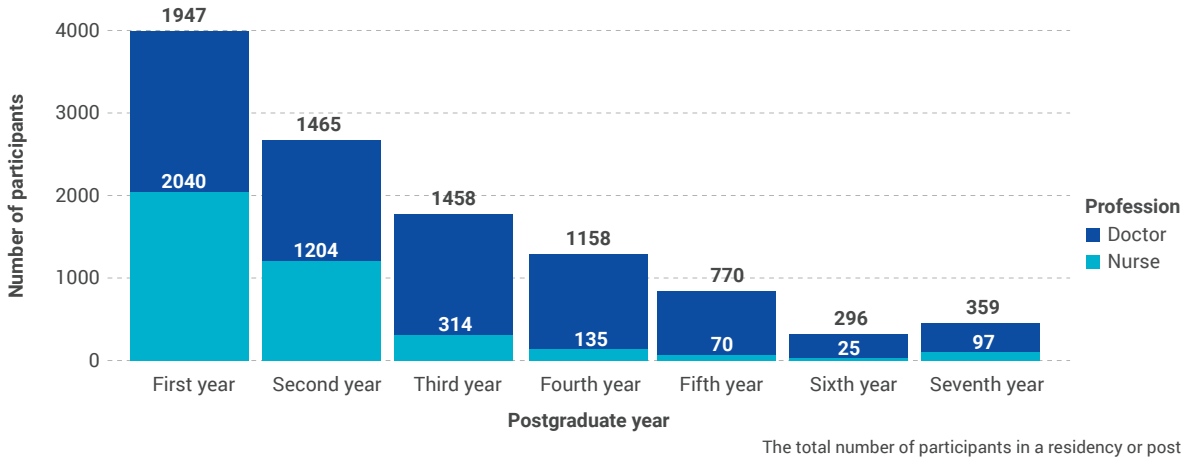
Figure A1.4. Number of responses, by medical specialty (doctors only, n = 37 904)



Note: Diagnostic specialties comprise clinical biology, diagnostic radiology, microbiology – bacteriology, nuclear medicine, pathological anatomy, and radiology. Other specialties comprise biological chemistry, biological haematology, pharmacology and others not included on the list. Primary care specialties are community medicine and general practitioners. Clinical specialties include (but are not limited to) internal medicine, paediatrics and occupational medicine. Anaesthetics and obstetrics and gynaecology are included in surgical specialties.

Approximately 10% of respondents were doing their postgraduate training (Fig. A1.5). Most are first- or second-year trainees. Looking at doctors, one in four respondents is a medical resident, which is higher than the proportion of estimated junior doctors in the EU (16%).[8]

Figure A1.5. Frequency of postgraduate training years, by profession (n = 10 871)



8 Data obtained from the European Junior Doctors Association website, which estimates the number of junior doctors represented by the Association.

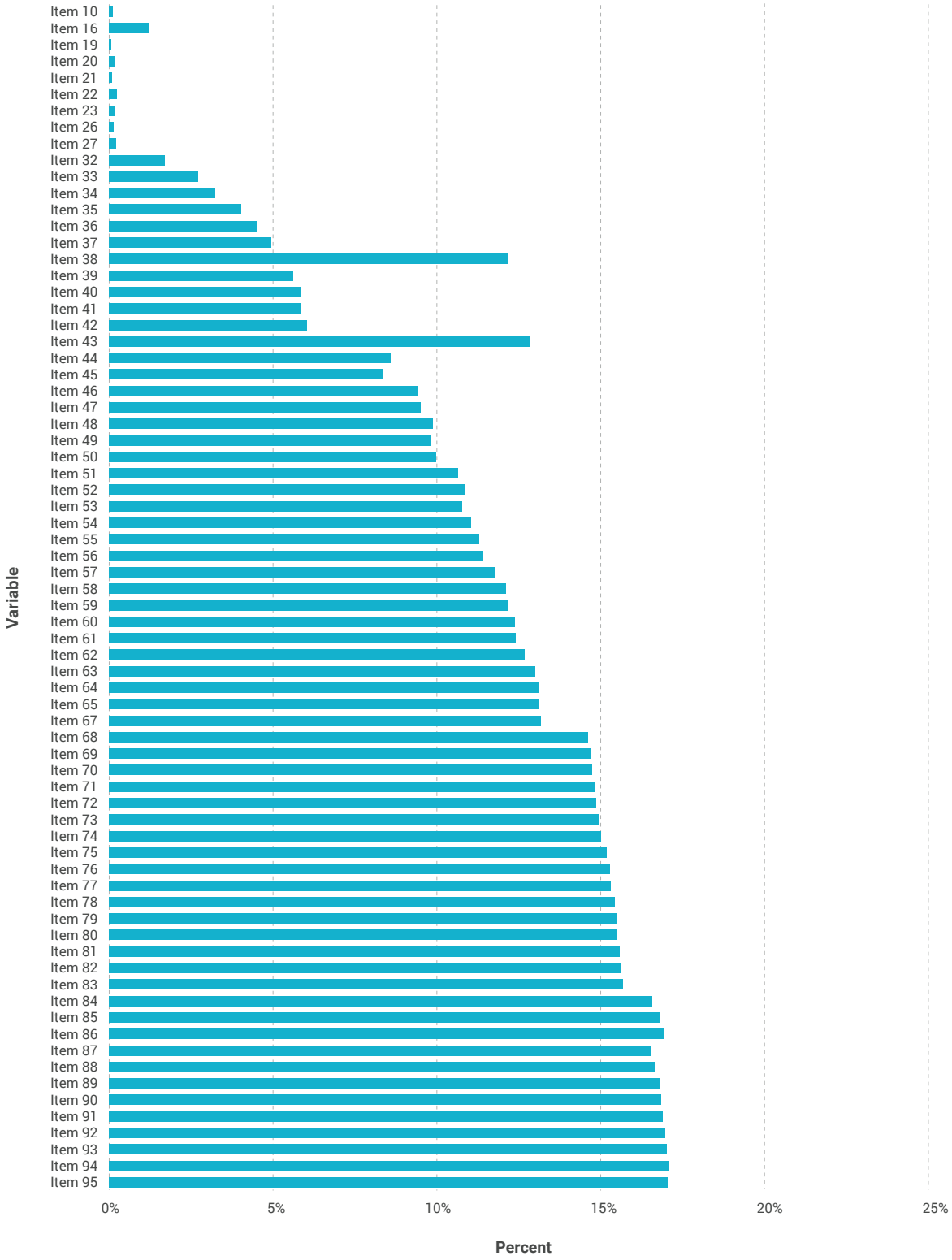
Data collection and analysis

The data were collected using electronic data collection software tailored to this project. The platform was developed using JavaScript (Svelte) and was hosted on Netlify. The domain was a subdomain of the website of the WHO Collaborating Centre for Mental Health Services Research and Training in Madrid, Spain. The database is located in the Central EU Servers of Supabase in Frankfurt, Germany. Additional back-ups were periodically updated and stored in a local server located at the Centre for Scientific Computing at the Universidad Autónoma de Madrid. The database is password-protected and only accessible by the research team. The dataset is fully anonymized and the General Data Protection Regulation of the EU does not apply.

Two types of statistical analyses were conducted for each main objective. To describe the sample characteristics, frequencies, percentages, medians, means and their associated dispersion statistics are provided where appropriate. Sum scores and dichotomous scoring were computed for the PHQ-9, GAD-7 and CAGE scales, using cut-offs validated across countries. To estimate the associations between workplace exposures and mental health outcomes, logistic multilevel regression models were used, adjusted for age, gender, profession and country. The choice of confounding variables was only partially informed by prior causal knowledge. Hence, the models are unbiased in showing exposure–outcome associations, but potentially biased for estimating causal effects.

All analyses were conducted using complete case data. We did not apply imputation methods, based on the assumption that missingness was largely at random. The primary pattern observed was an increase in missing responses as the survey progressed (Fig. A1.6). Consequently, the number of valid responses varies across variables and their combinations, leading to differences in sample sizes reported in different sections of the report.

Figure A1.6. Proportion of missing values, by survey progress



Note: Conditional items (i.e., items displayed to some workers only based on previous responses, such as medical specialties for doctors or number of children for doctors and nurses living with children) have been omitted for clarity.

R and R Studio were used for data cleaning and analysis. No interim analyses were performed during the data collection period.

Biases

Interpretation of the results must consider three key methodological limitations.

First, probabilistic sampling was not feasible and accurate response rates could not be calculated. This increases the risk of self-selection bias – both among people who received the survey invitation and those who chose to participate. As a result, caution is needed when generalizing the findings to the wider population of doctors and nurses, especially in countries with lower response levels – response rates have been estimated using the number of professionals in each country.

Second, all data were collected through self-report measures. While these instruments use thresholds that have been validated across most EU countries, they do not allow for clinical diagnosis and may overestimate the prevalence of certain mental health conditions.

Third, the survey was cross-sectional, capturing data at a single point in time. This limits the ability to draw conclusions about causality and raises the possibility of reverse causation in observed associations between stressors and mental health outcomes.

References

1. National Health Workforce Accounts Data Portal [online database]. Geneva: World Health Organization; 2025 (https://apps.who.int/nhwaportal).

Annex 2: Country profiles

Austria | Country profile

Background

Total country population: **8 917 205**

	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Austria	168.2	1.9	25.0
EU27+2	123.5	2.2	32.0

Sample characteristics

Female doctors — number of respondents: **624**; proportion of responses in relation to total subgroup population: **2.5%**

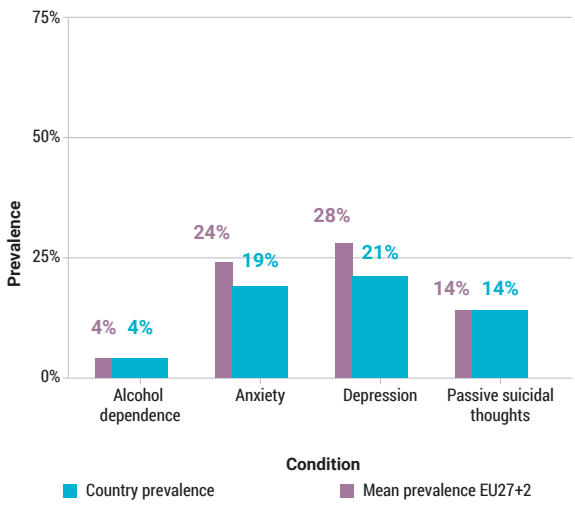
Male doctors — number of respondents: **445**; proportion of responses in relation to total subgroup population: **1.8%**

Female nurses — number of respondents: **430**; proportion of responses in relation to total subgroup population: **0.5%**

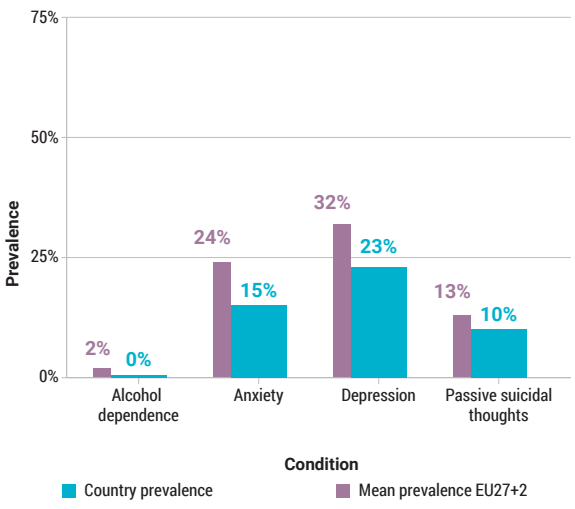
Male nurses — number of respondents: **87**; proportion of responses in relation to total subgroup population: **0.6%**

Prevalence of mental health conditions

Doctors



Nurses



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

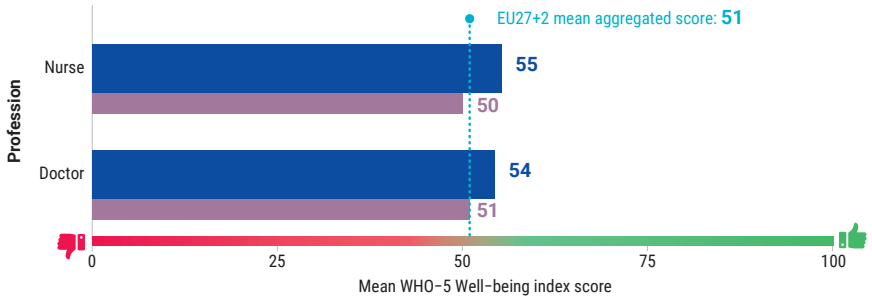
Austria | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

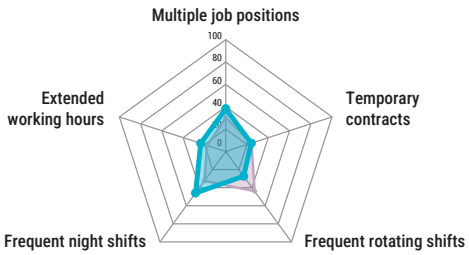
Austria
EU27+2



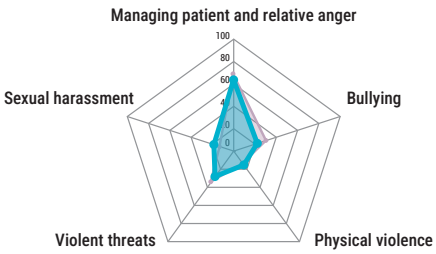
Working conditions

Risk factors

Working hours and contracts

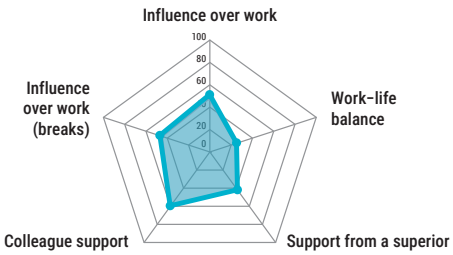


Violence

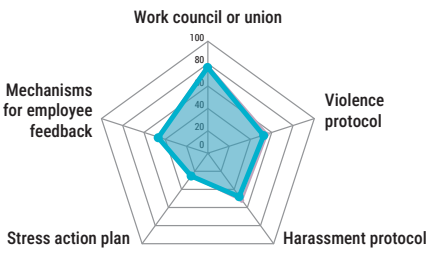


Protective factors

Social support and control



Workplace support structures



Austria
EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	9.2%	9.1%
Nurses	12.5%	15.4%

Sick leave due to mental health problems

		EU27+ average
Doctors	6.0%	7.4%
Nurses	10.5%	10.5%

Belgium | Country profile

Background

Total country population: **11 555 997**

	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Belgium	133.3	3.5	39.7
EU27+2	123.5	2.2	32.0

Sample characteristics

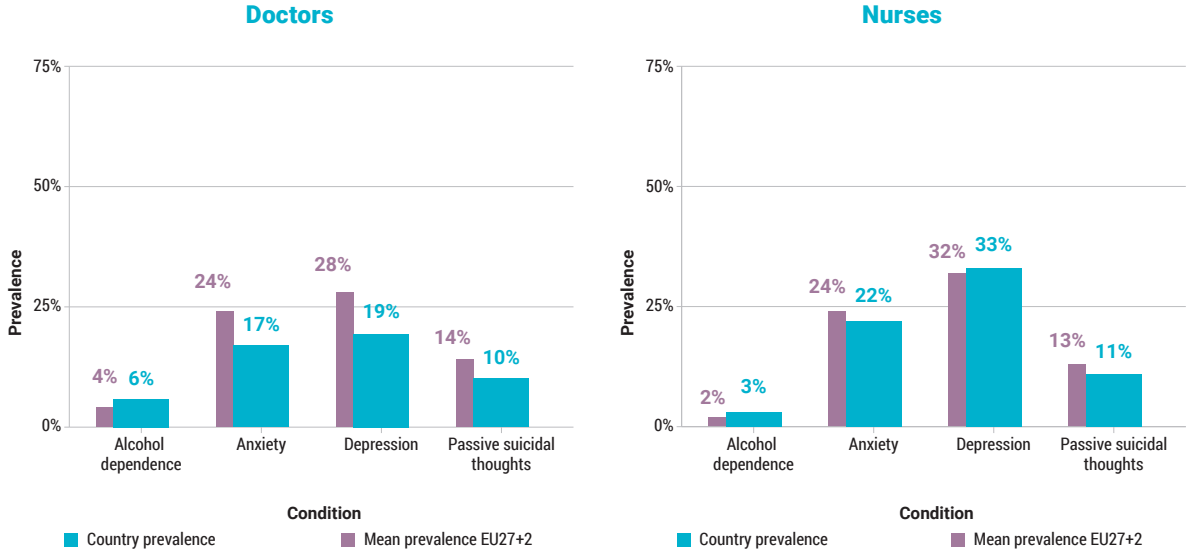
Female doctors
number of respondents: **403**
proportion of responses in relation to total subgroup population: **2.2%**

Male doctors
number of respondents: **222**
proportion of responses in relation to total subgroup population: **1.2%**

Female nurses
number of respondents: **532**
proportion of responses in relation to total subgroup population: **N/A**

Male nurses
number of respondents: **117**
proportion of responses in relation to total subgroup population: **N/A**

Prevalence of mental health conditions



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

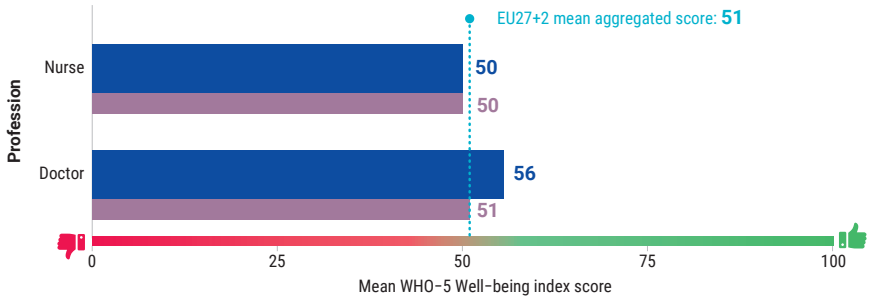
Belgium | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

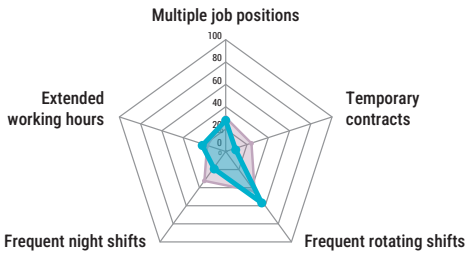
Belgium
EU27+2



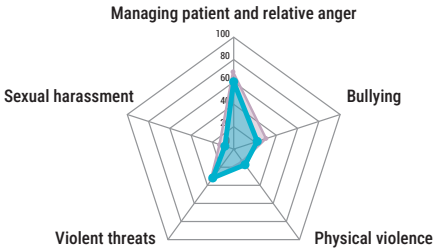
Working conditions

Risk factors

Working hours and contracts

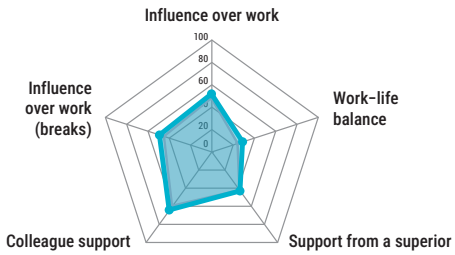


Violence

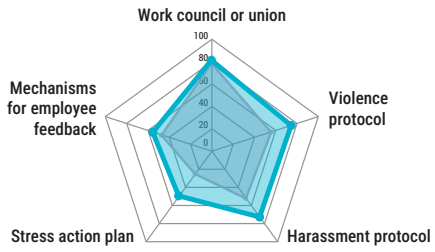


Protective factors

Social support and control



Workplace support structures



Belgium
EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	6.8%	9.1%
Nurses	13.8%	15.4%

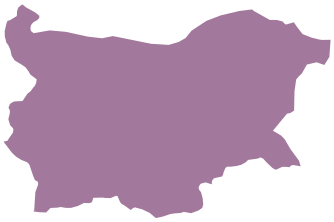
Sick leave due to mental health problems

		EU27+ average
Doctors	7.1%	7.4%
Nurses	14.8%	10.5%

Bulgaria | Country profile

Background

Total country population: **6 927 288**



	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Bulgaria	82.6	1.1	52.1
EU27+2	123.5	2.2	32.0

Sample characteristics

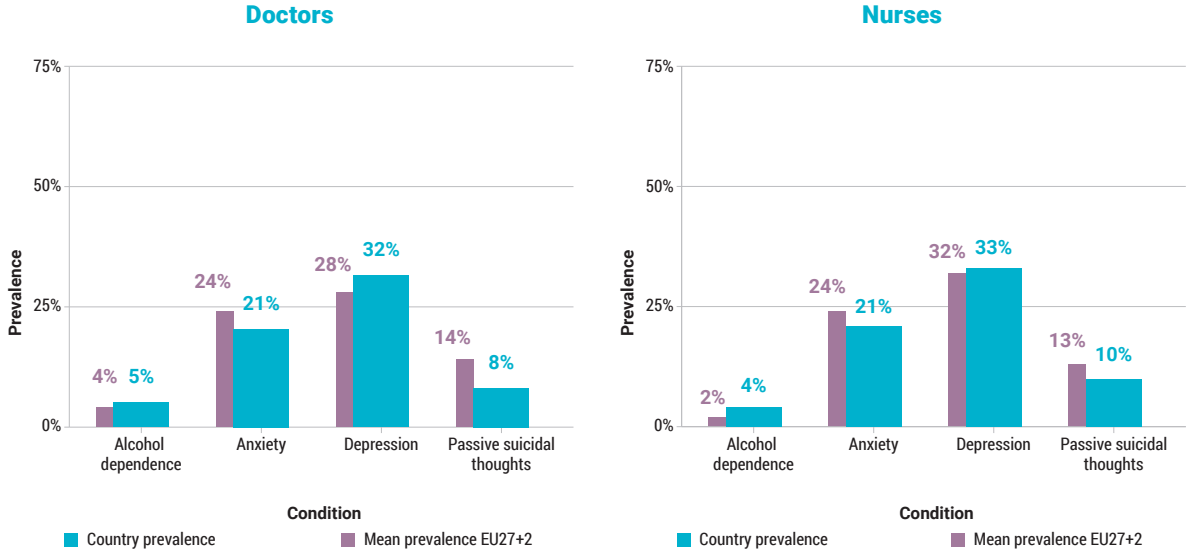
Female doctors
number of respondents: **261**
proportion of responses in relation to total subgroup population: **1.6%**

Male doctors
number of respondents: **144**
proportion of responses in relation to total subgroup population: **1.2%**

Female nurses
number of respondents: **140**
proportion of responses in relation to total subgroup population: **N/A**

Male nurses
number of respondents: **6**
proportion of responses in relation to total subgroup population: **N/A**

Prevalence of mental health conditions



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

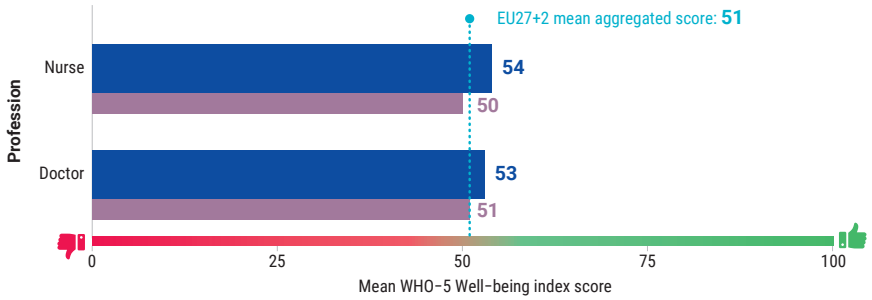
Bulgaria | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

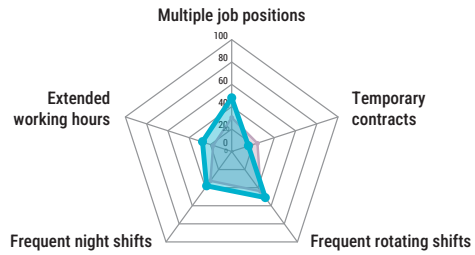
Bulgaria
EU27+2



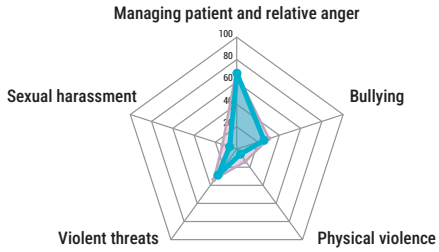
Working conditions

Risk factors

Working hours and contracts

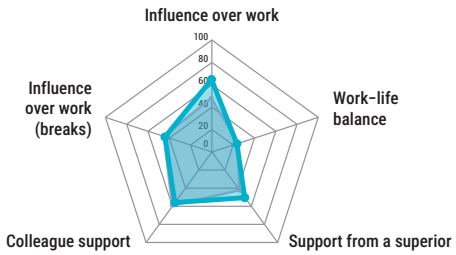


Violence

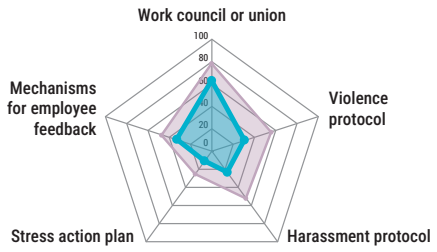


Protective factors

Social support and control



Workplace support structures



Bulgaria
EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	4.8%	9.1%
Nurses	15.5%	15.4%

Sick leave due to mental health problems

		EU27+ average
Doctors	2.2%	7.4%
Nurses	3.3%	10.5%

Croatia | Country profile

Background

Total country population: **4 047 200**

	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Croatia	111.1	0.6	24.1
EU27+2	123.5	2.2	32.0

Sample characteristics

Female doctors
number of respondents: **193**
proportion of responses in relation to total subgroup population: **2.0%**

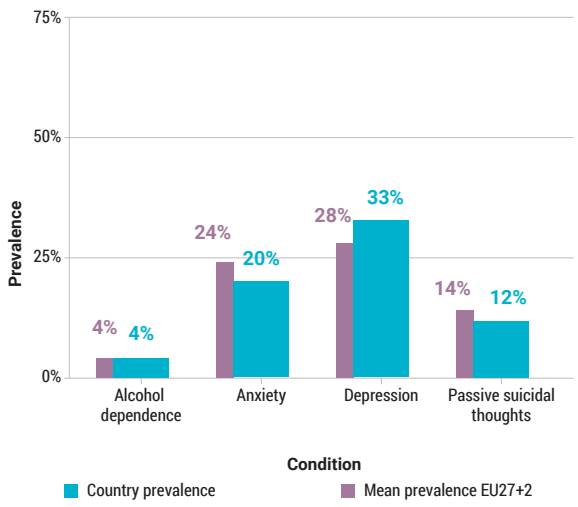
Male doctors
number of respondents: **66**
proportion of responses in relation to total subgroup population: **1.2%**

Female nurses
number of respondents: **247**
proportion of responses in relation to total subgroup population: **3.1%**

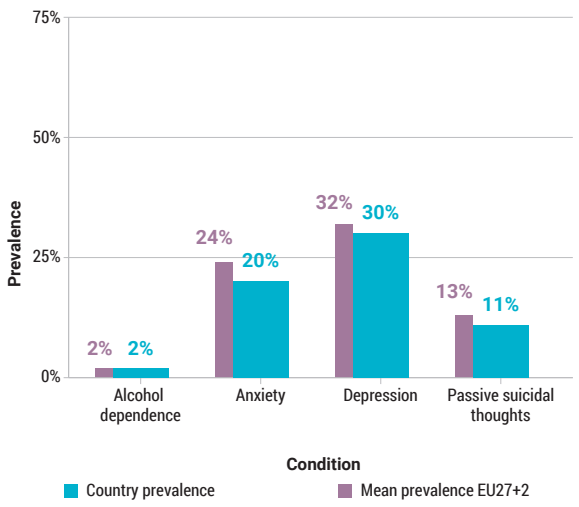
Male nurses
number of respondents: **24**
proportion of responses in relation to total subgroup population: **2.3%**

Prevalence of mental health conditions

Doctors



Nurses



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

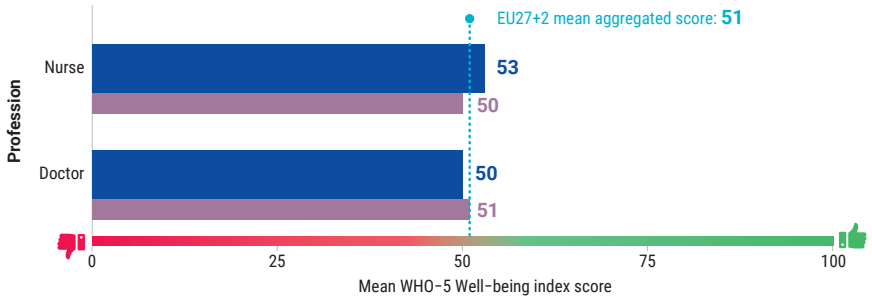
Croatia | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

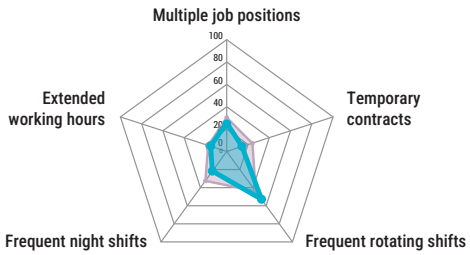
Croatia
EU27+2



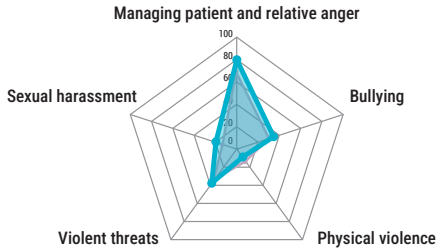
Working conditions

Risk factors

Working hours and contracts

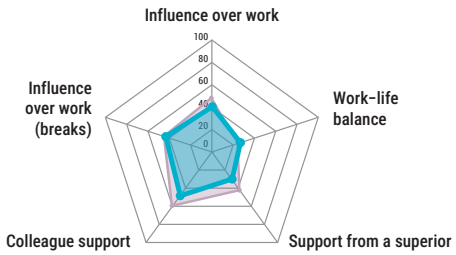


Violence

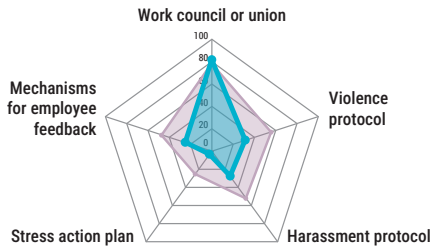


Protective factors

Social support and control



Workplace support structures



Croatia EU27+2

Sick leave and intention to leave

Reported intention to leave profession

	Croatia	EU27+ average
Doctors	18.1%	9.1%
Nurses	27.5%	15.4%

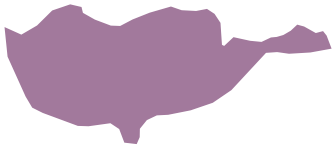
Sick leave due to mental health problems

	Croatia	EU27+ average
Doctors	4.4%	7.4%
Nurses	6.4%	10.5%

Cyprus | Country profile

Background

Total country population: **1 207 361**



	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Cyprus	79.3	1.0	37.6
EU27+2	123.5	2.2	32.0

Sample characteristics

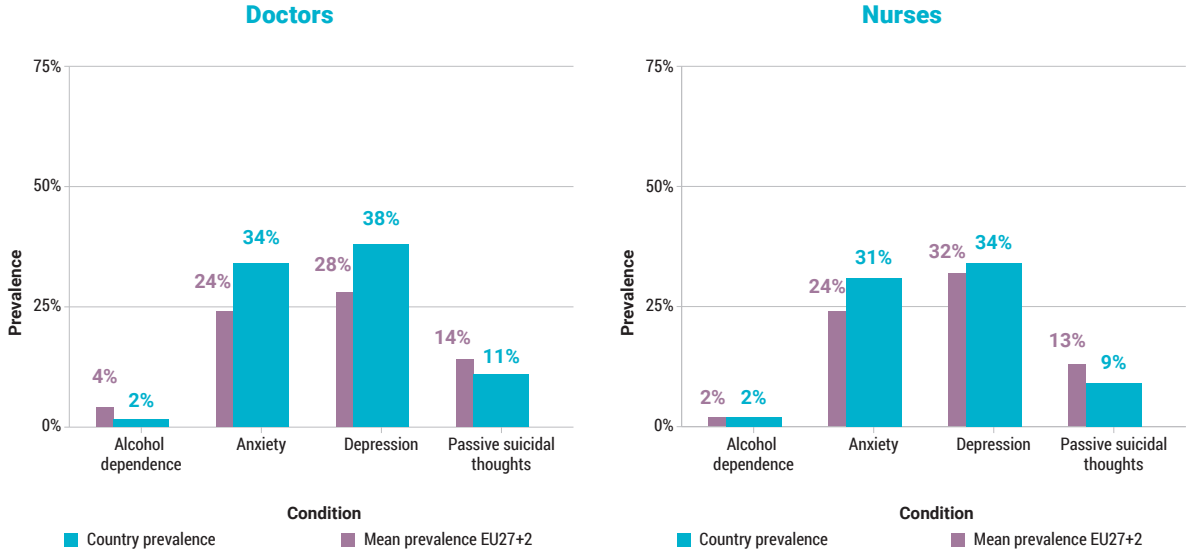
Female doctors — number of respondents: **132**; proportion of responses in relation to total subgroup population: **7.1%**

Male doctors — number of respondents: **109**; proportion of responses in relation to total subgroup population: **4.1%**

Female nurses — number of respondents: **216**; proportion of responses in relation to total subgroup population: **N/A**

Male nurses — number of respondents: **58**; proportion of responses in relation to total subgroup population: **N/A**

Prevalence of mental health conditions



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

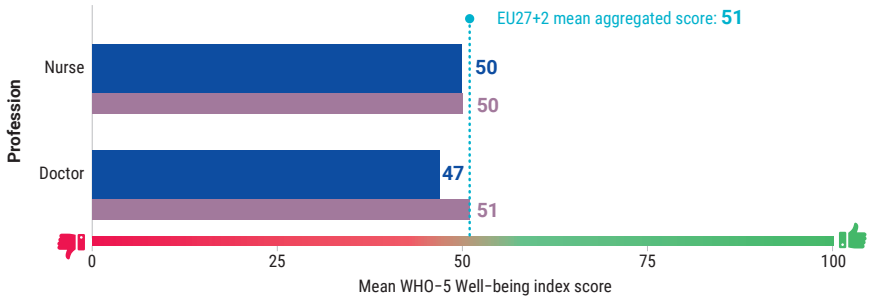
Cyprus | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

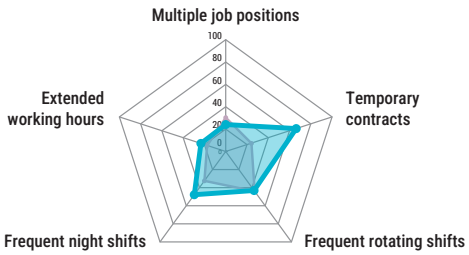
Cyprus
EU27+2



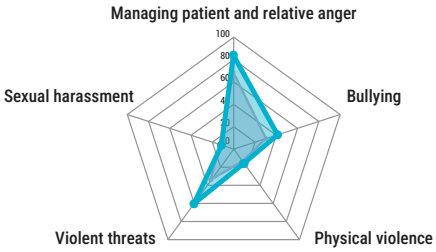
Working conditions

Risk factors

Working hours and contracts

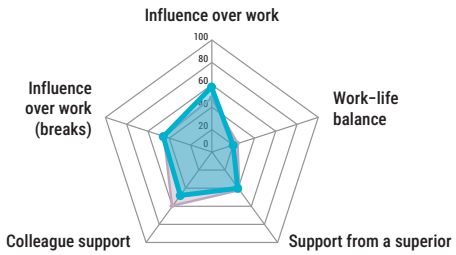


Violence

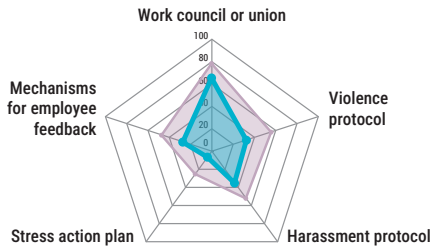


Protective factors

Social support and control



Workplace support structures



Cyprus
EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	9.0%	9.1%
Nurses	16.3%	15.4%

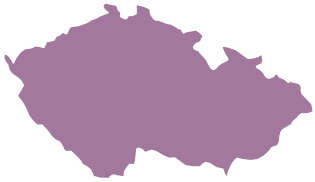
Sick leave due to mental health problems

		EU27+ average
Doctors	6.3%	7.4%
Nurses	10.6%	10.5%

Czechia | Country profile

Background

Total country population: **10 698 896**



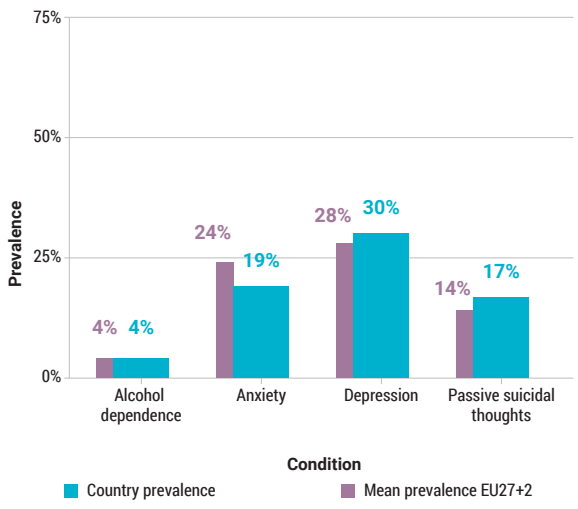
	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Czechia	–	2.0	32.3
EU27+2	123.5	2.2	32.0

Sample characteristics

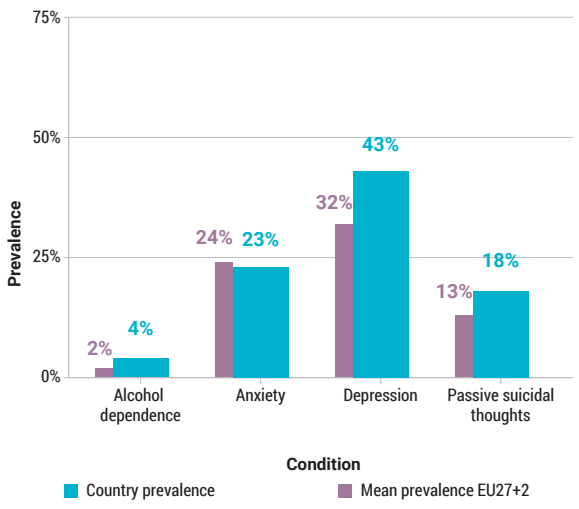
	number of respondents	proportion of responses in relation to total subgroup population
Female doctors	**2 987**	**11.8%**
Male doctors	**1 491**	**8.0%**
Female nurses	**452**	**0.5%**
Male nurses	**46**	**2.6%**

Prevalence of mental health conditions

Doctors



Nurses



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

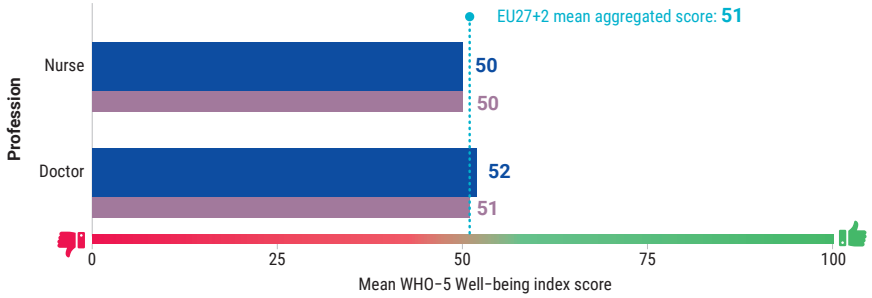
Czechia | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

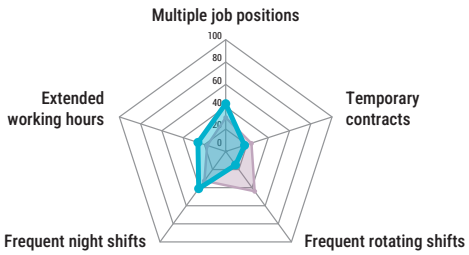
Czechia
EU27+2



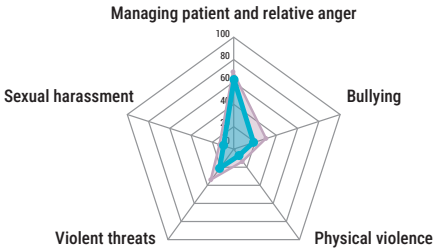
Working conditions

Risk factors

Working hours and contracts

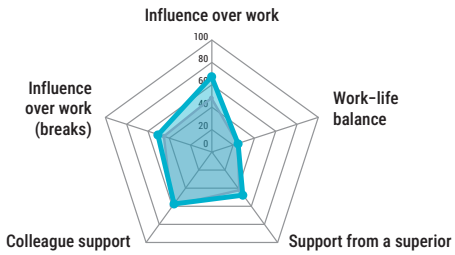


Violence

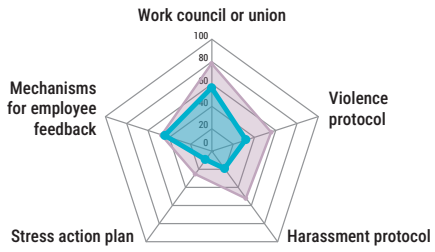


Protective factors

Social support and control



Workplace support structures



Czechia EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	8.2%	9.1%
Nurses	12.5%	15.4%

Sick leave due to mental health problems

		EU27+ average
Doctors	3.2%	7.4%
Nurses	6.0%	10.5%

Denmark | Country profile

Background

Total country population: **5 831 404**

	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Denmark	137.8	2.7	28.3
EU27+2	123.5	2.2	32.0

Sample characteristics

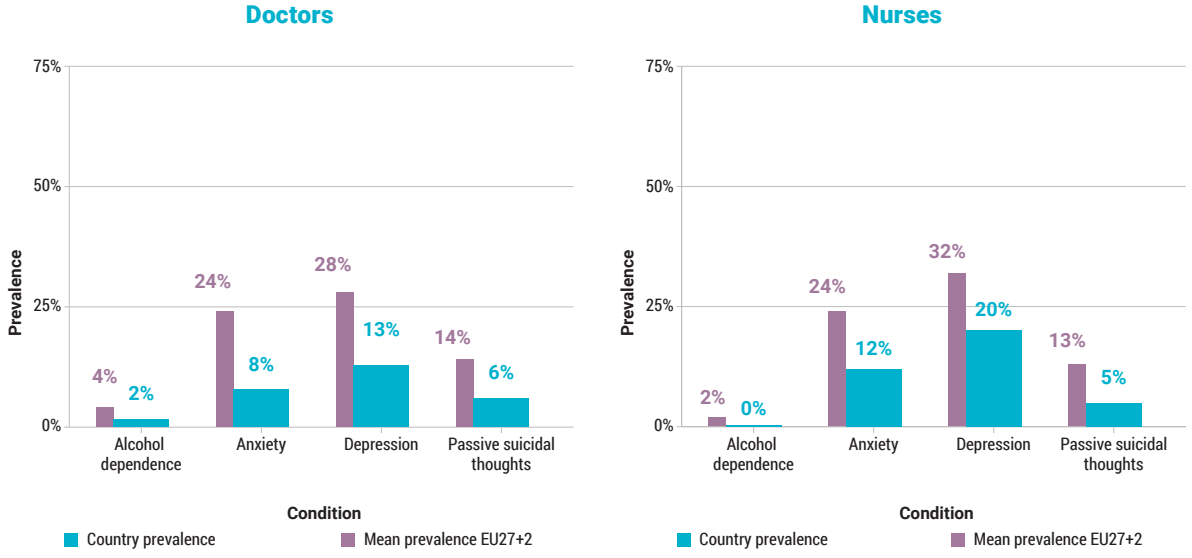
Female doctors
number of respondents: **1 468**
proportion of responses in relation to total subgroup population: **10.2%**

Male doctors
number of respondents: **886**
proportion of responses in relation to total subgroup population: **7.7%**

Female nurses
number of respondents: **997**
proportion of responses in relation to total subgroup population: **1.5%**

Male nurses
number of respondents: **42**
proportion of responses in relation to total subgroup population: **1.4%**

Prevalence of mental health conditions



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

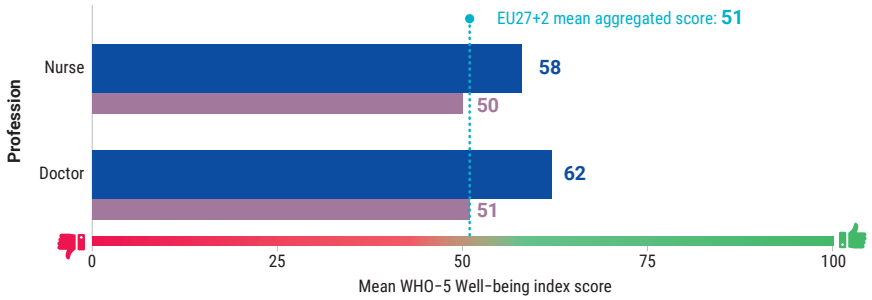
Denmark | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

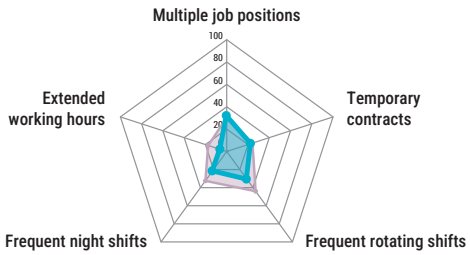
Denmark
EU27+2



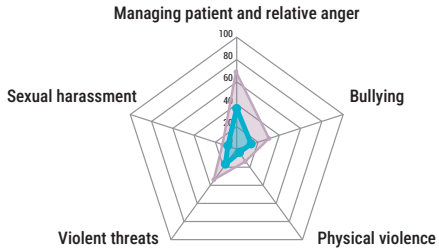
Working conditions

Risk factors

Working hours and contracts

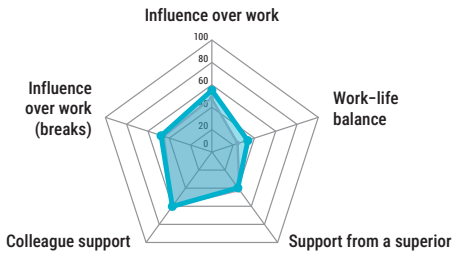


Violence

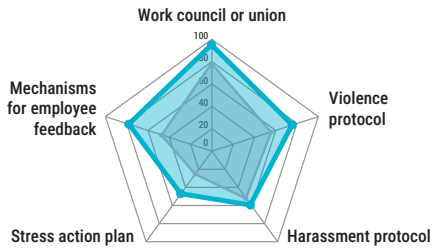


Protective factors

Social support and control



Workplace support structures



Denmark EU27+2

Sick leave and intention to leave

Reported intention to leave profession

	Denmark	EU27+ average
Doctors	10.0%	9.1%
Nurses	15.4%	15.4%

Sick leave due to mental health problems

	Denmark	EU27+ average
Doctors	7.3%	7.4%
Nurses	12.7%	10.5%

Estonia | Country profile

Background

Total country population: **1 331 057**

	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Estonia	101.9	2.0	32.9
EU27+2	123.5	2.2	32.0

Sample characteristics

Female doctors
number of respondents: **380**
proportion of responses in relation to total subgroup population: **11.7%**

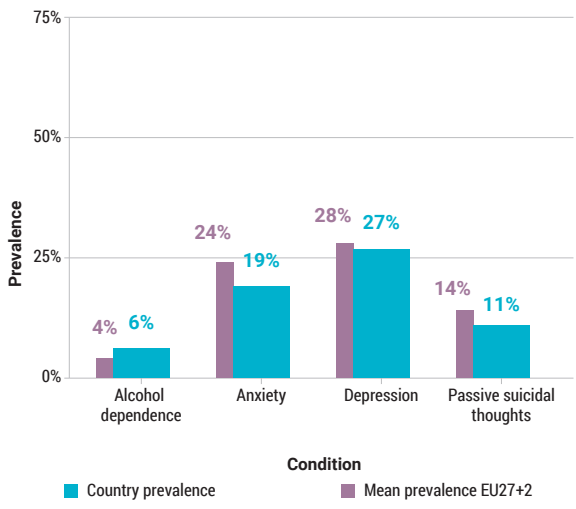
Male doctors
number of respondents: **84**
proportion of responses in relation to total subgroup population: **6.8%**

Female nurses
number of respondents: **475**
proportion of responses in relation to total subgroup population: **5.6%**

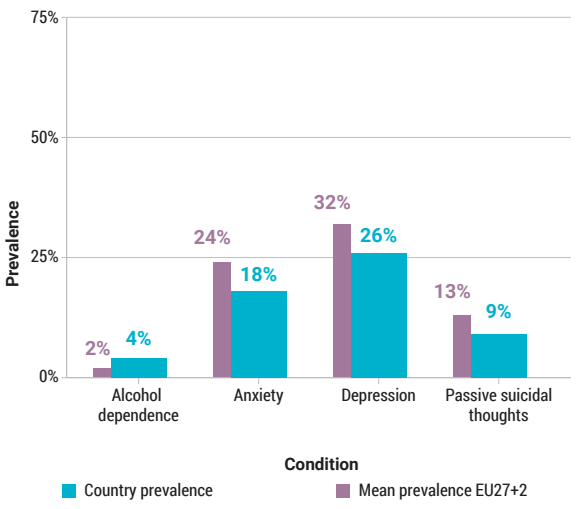
Male nurses
number of respondents: **12**
proportion of responses in relation to total subgroup population: **3.5%**

Prevalence of mental health conditions

Doctors



Nurses



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

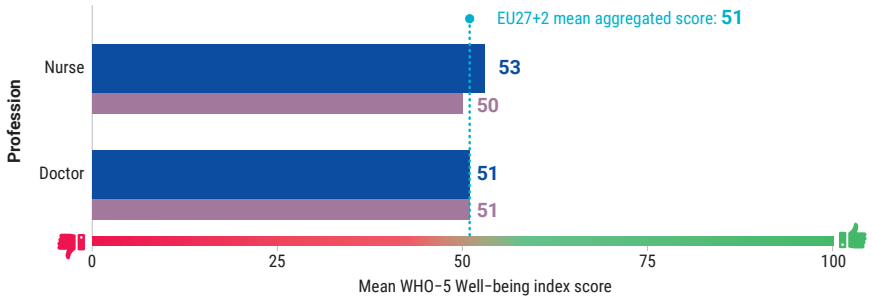
Estonia | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

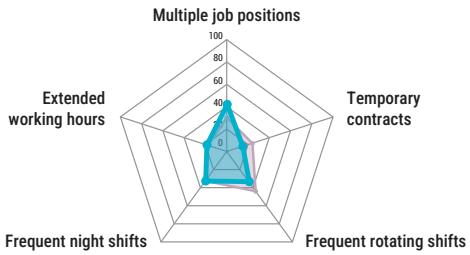
Estonia
EU27+2



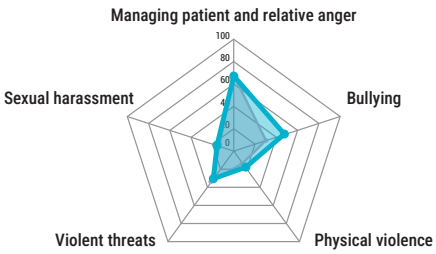
Working conditions

Risk factors

Working hours and contracts

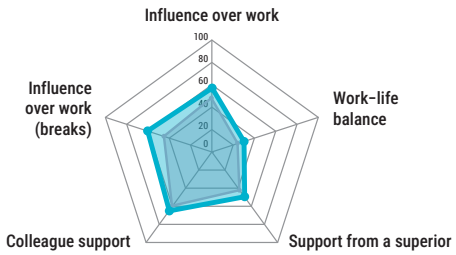


Violence

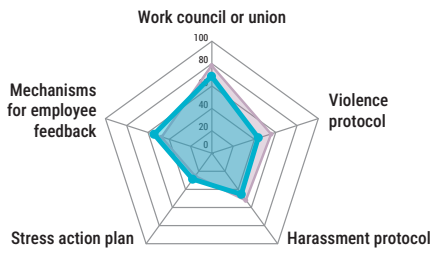


Protective factors

Social support and control



Workplace support structures



Estonia
EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	5.4%	9.1%
Nurses	12.1%	15.4%

Sick leave due to mental health problems

		EU27+ average
Doctors	9.9%	7.4%
Nurses	10.7%	10.5%

Finland | Country profile

Background

Total country population: **5 530 719**

	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Finland	173.3	4.5	24.4
EU27+2	123.5	2.2	32.0

Sample characteristics

Female doctors — number of respondents: **83** — proportion of responses in relation to total subgroup population: **0.7%**

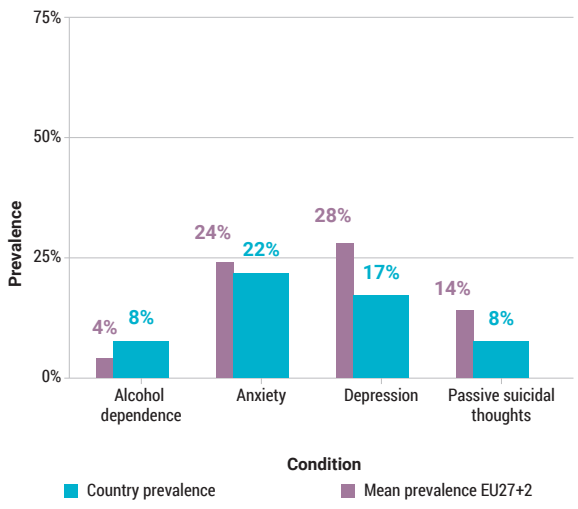
Male doctors — number of respondents: **30** — proportion of responses in relation to total subgroup population: **0.4%**

Female nurses — number of respondents: **2 009** — proportion of responses in relation to total subgroup population: **N/A**

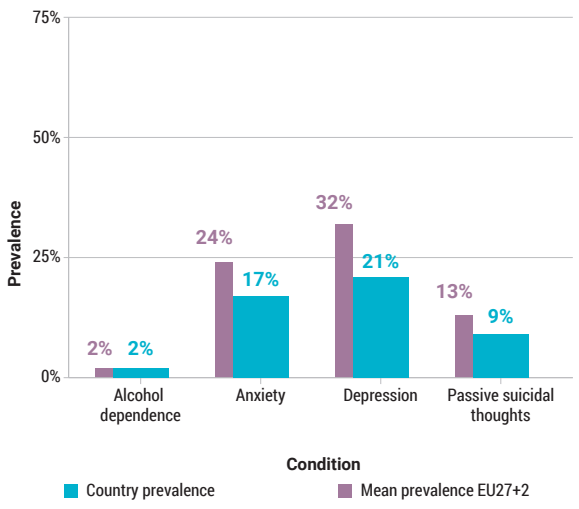
Male nurses — number of respondents: **101** — proportion of responses in relation to total subgroup population: **N/A**

Prevalence of mental health conditions

Doctors



Nurses



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

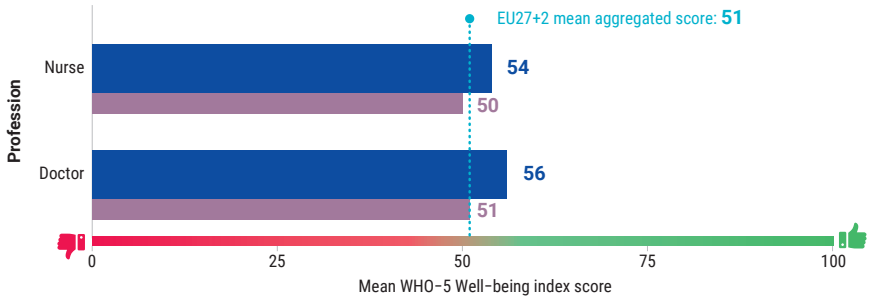
Finland | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

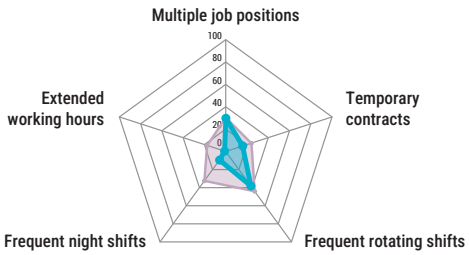
Finland
EU27+2



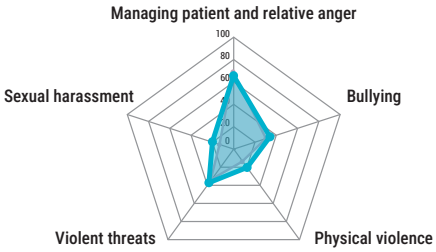
Working conditions

Risk factors

Working hours and contracts

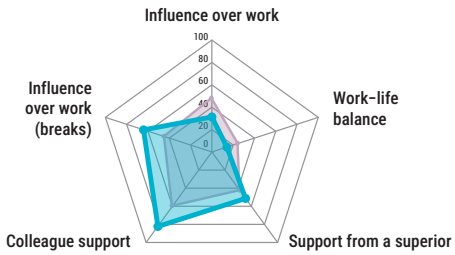


Violence

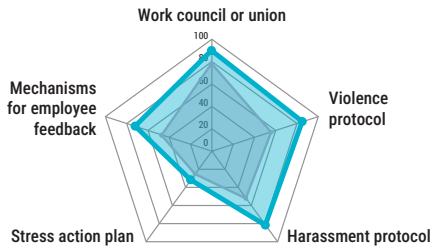


Protective factors

Social support and control



Workplace support structures



Finland
EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	5.5%	9.1%
Nurses	13.6%	15.4%

Sick leave due to mental health problems

		EU27+ average
Doctors	11.9%	7.4%
Nurses	16.9%	10.5%

France | Country profile

Background

Total country population: **67 391 582**

	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
France	129.5	3.0	41.7
EU27+2	123.5	2.2	32.0

Sample characteristics

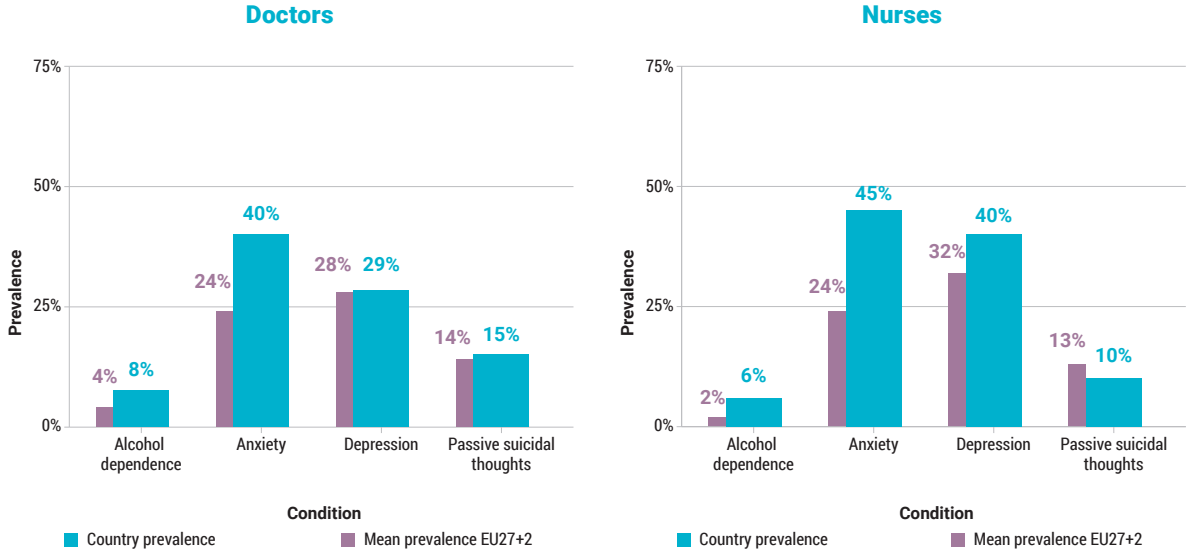
Female doctors
number of respondents: **1 492**
proportion of responses in relation to total subgroup population: **1.4%**

Male doctors
number of respondents: **661**
proportion of responses in relation to total subgroup population: **0.6%**

Female nurses
number of respondents: **379**
proportion of responses in relation to total subgroup population: **N/A**

Male nurses
number of respondents: **79**
proportion of responses in relation to total subgroup population: **N/A**

Prevalence of mental health conditions



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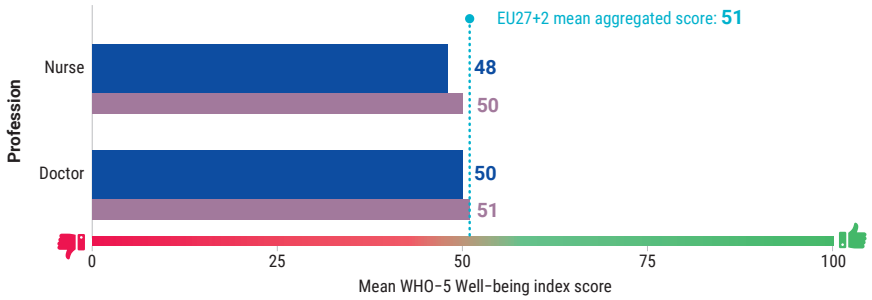
France | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

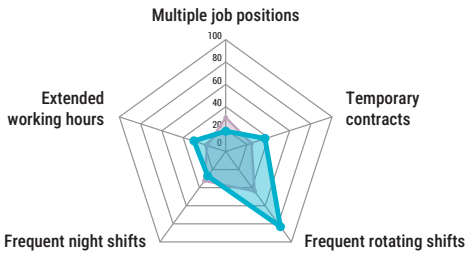
France
EU27+2



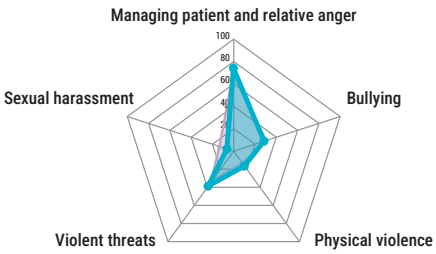
Working conditions

Risk factors

Working hours and contracts

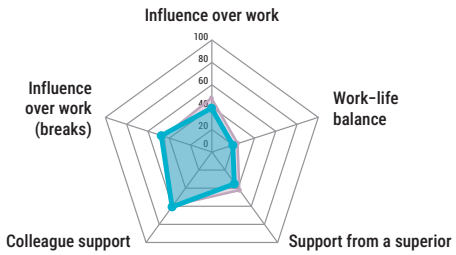


Violence

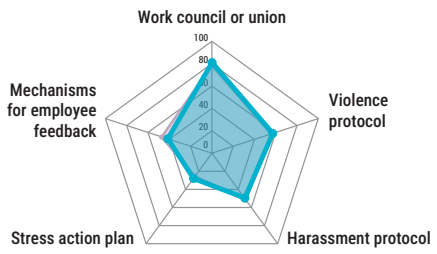


Protective factors

Social support and control



Workplace support structures



France
EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	7.8%	9.1%
Nurses	21.9%	15.4%

Sick leave due to mental health problems

		EU27+ average
Doctors	12.8%	7.4%
Nurses	14.8%	10.5%

Germany | Country profile

Background

Total country population: **83 240 525**

	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Germany	161.7	3.1	43.6
EU27+2	123.5	2.2	32.0

Sample characteristics

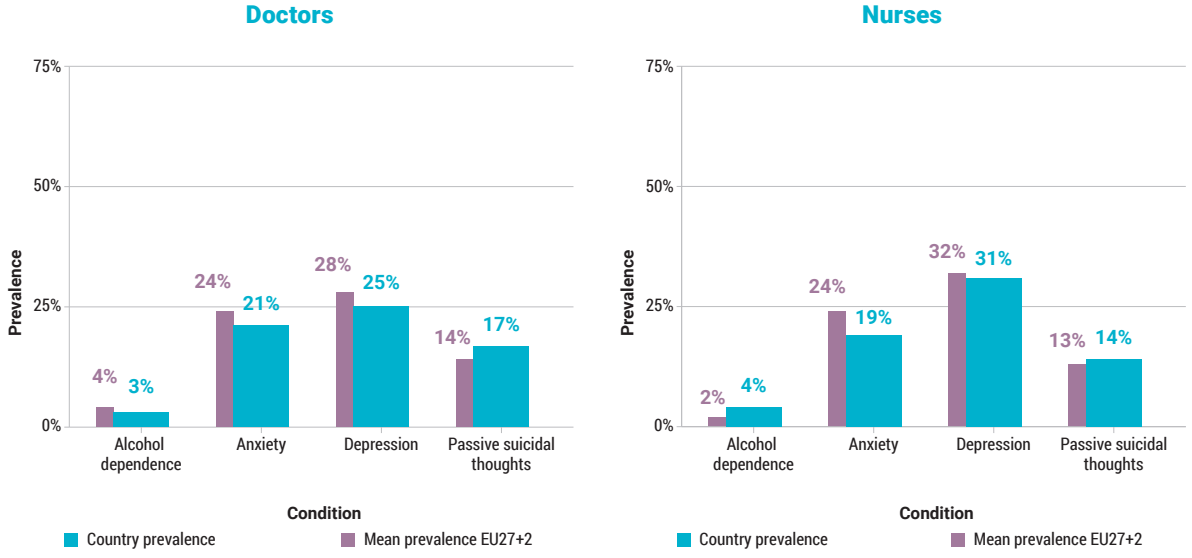
Female doctors
number of respondents: **2 238**
proportion of responses in relation to total subgroup population: **1.2%**

Male doctors
number of respondents: **1 040**
proportion of responses in relation to total subgroup population: **0.5%**

Female nurses
number of respondents: **614**
proportion of responses in relation to total subgroup population: **N/A**

Male nurses
number of respondents: **174**
proportion of responses in relation to total subgroup population: **N/A**

Prevalence of mental health conditions



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

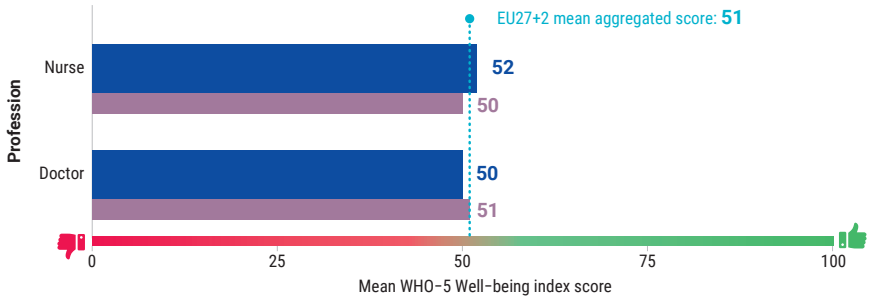
Germany | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

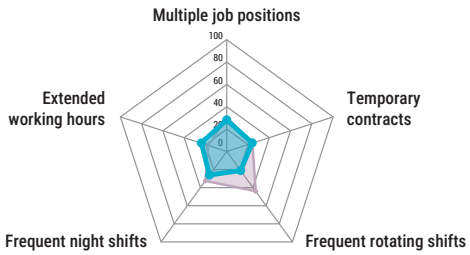
Germany
EU27+2



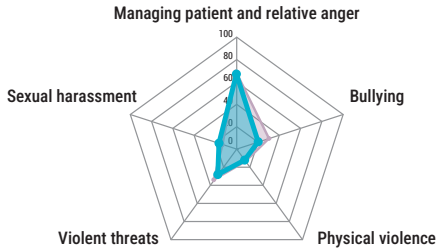
Working conditions

Risk factors

Working hours and contracts

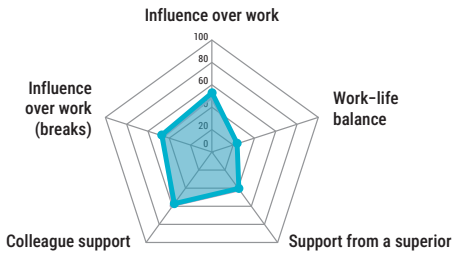


Violence

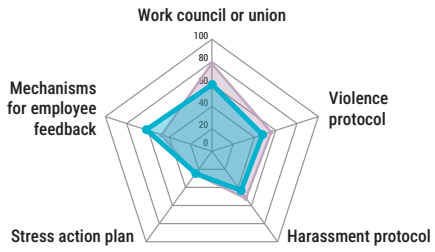


Protective factors

Social support and control



Workplace support structures



Germany
EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	10.6%	9.1%
Nurses	17.8%	15.4%

Sick leave due to mental health problems

		EU27+ average
Doctors	8.5%	7.4%
Nurses	16.8%	10.5%

Greece | Country profile

Background

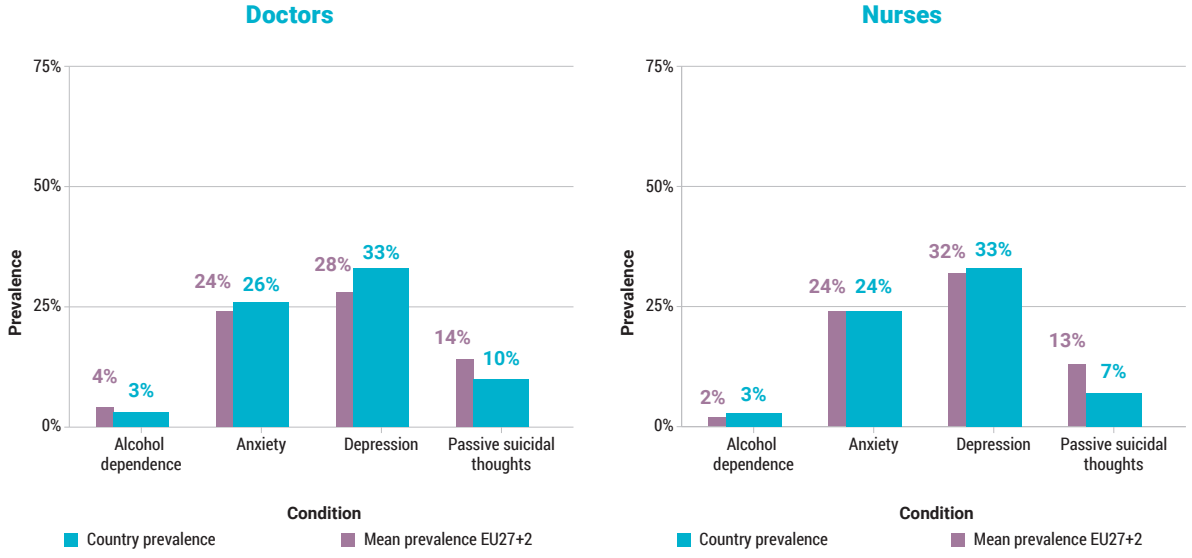
Total country population: **10 715 549**

	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Greece	91.5	0.6	32.2
EU27+2	123.5	2.2	32.0

Sample characteristics

	number of respondents	proportion of responses in relation to total subgroup population
Female doctors	533	1.8%
Male doctors	444	1.2%
Female nurses	1 136	N/A
Male nurses	219	N/A

Prevalence of mental health conditions



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

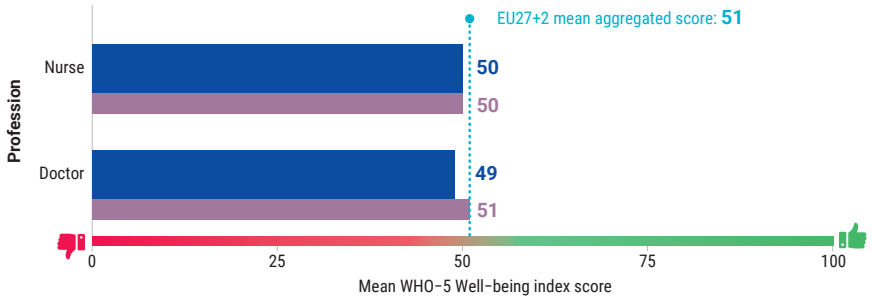
Greece | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

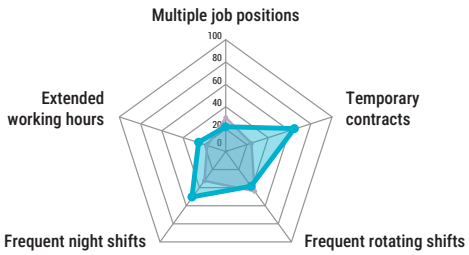
Greece
EU27+2



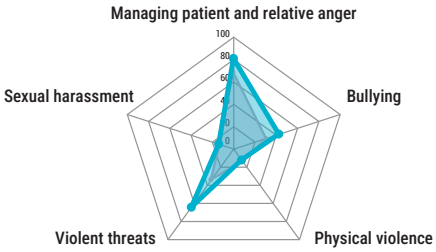
Working conditions

Risk factors

Working hours and contracts

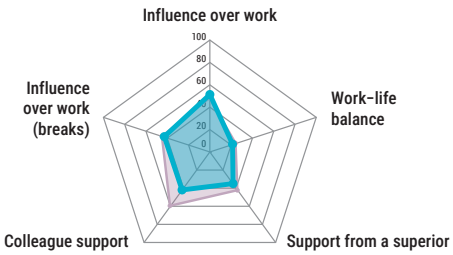


Violence

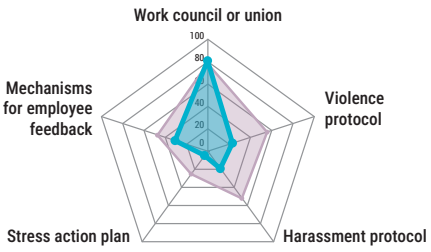


Protective factors

Social support and control



Workplace support structures



Greece
EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	8.7%	9.1%
Nurses	21.2%	15.4%

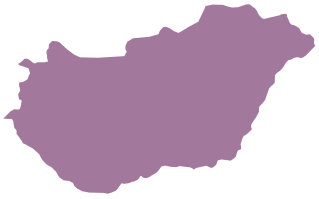
Sick leave due to mental health problems

		EU27+ average
Doctors	2.8%	7.4%
Nurses	3.6%	10.5%

Hungary | Country profile

Background

Total country population: **9 749 763**



	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Hungary	88.3	1.3	29.7
EU27+2	123.5	2.2	32.0

Sample characteristics

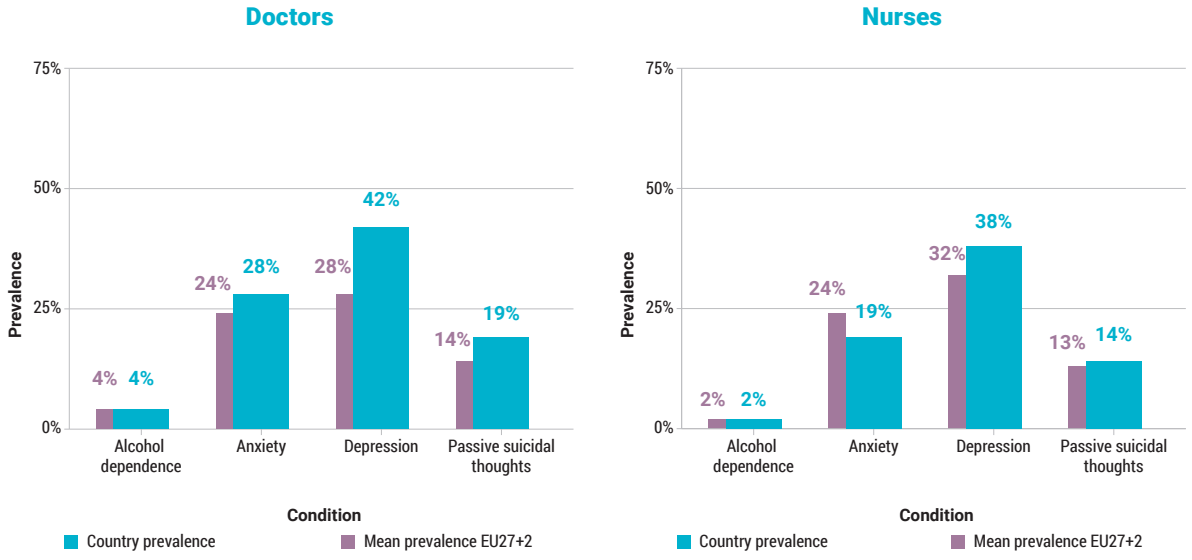
Female doctors
number of respondents: **1542**
proportion of responses in relation to total subgroup population: **8.4%**

Male doctors
number of respondents: **764**
proportion of responses in relation to total subgroup population: **5.8%**

Female nurses
number of respondents: **6 596**
proportion of responses in relation to total subgroup population: **16.5%**

Male nurses
number of respondents: **627**
proportion of responses in relation to total subgroup population: **26.2%**

Prevalence of mental health conditions



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

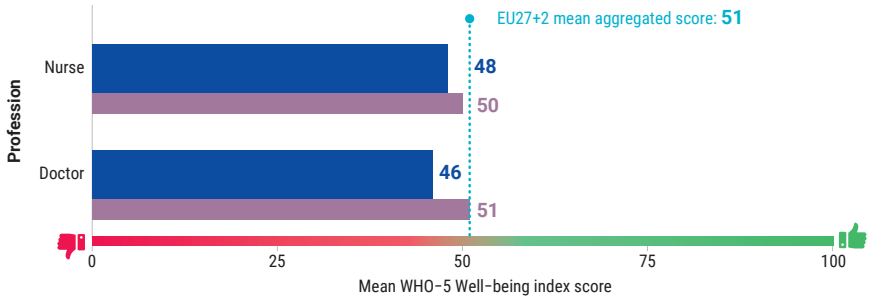
Hungary | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

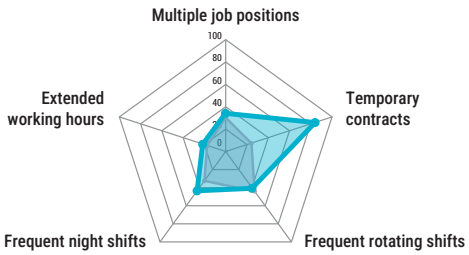
Hungary
EU27+2



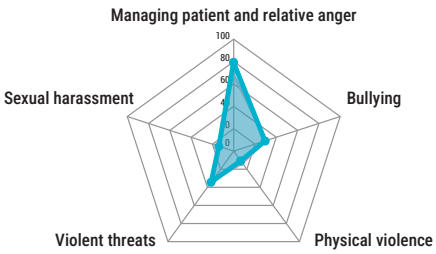
Working conditions

Risk factors

Working hours and contracts

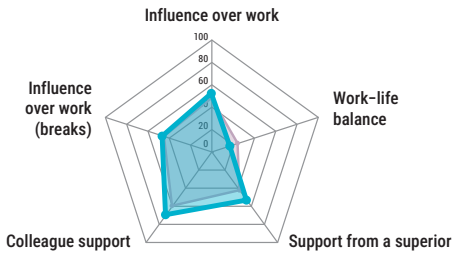


Violence

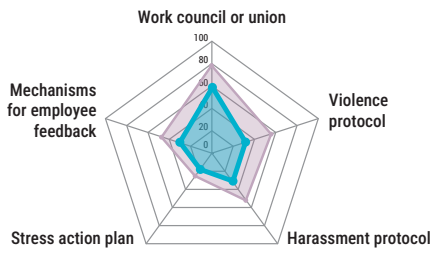


Protective factors

Social support and control



Workplace support structures



Hungary
EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	10.8%	9.1%
Nurses	21.3%	15.4%

Sick leave due to mental health problems

		EU27+ average
Doctors	5.4%	7.4%
Nurses	4.4%	10.5%

Iceland | Country profile

Background

Total country population: **366 425**

	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Iceland	190.4	4.3	39.7
EU27+2	123.5	2.2	32.0

Sample characteristics

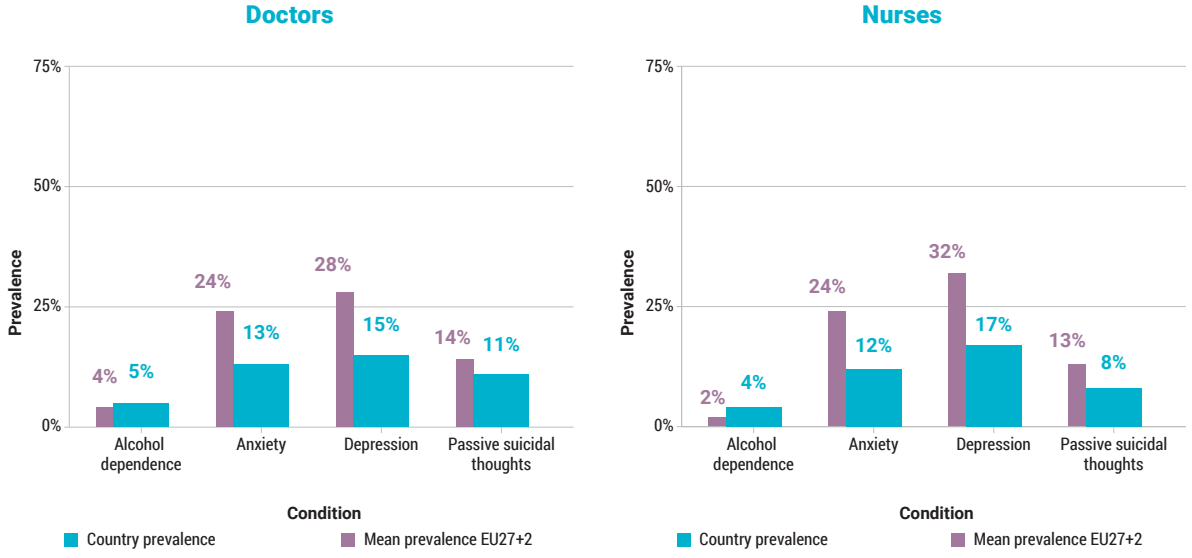
Female doctors — number of respondents: **255**; proportion of responses in relation to total subgroup population: **44.7%**

Male doctors — number of respondents: **225**; proportion of responses in relation to total subgroup population: **27.0%**

Female nurses — number of respondents: **542**; proportion of responses in relation to total subgroup population: **N/A**

Male nurses — number of respondents: **23**; proportion of responses in relation to total subgroup population: **N/A**

Prevalence of mental health conditions



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

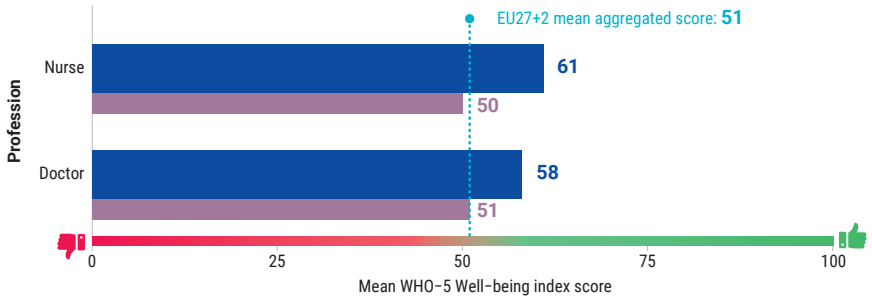
Iceland | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

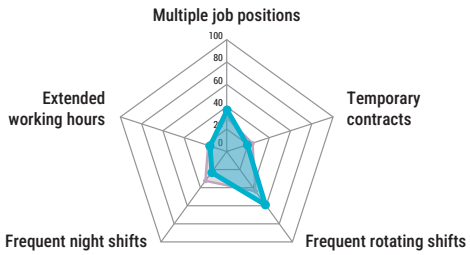
Iceland
EU27+2



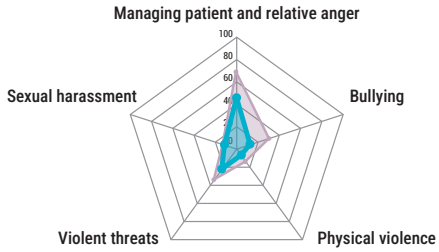
Working conditions

Risk factors

Working hours and contracts

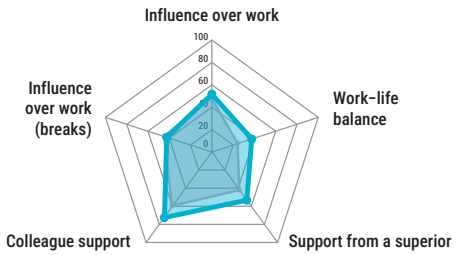


Violence

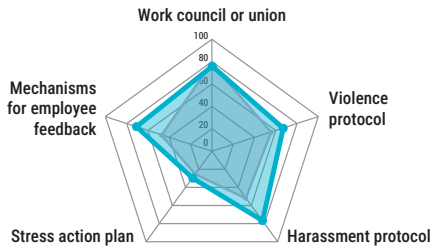


Protective factors

Social support and control



Workplace support structures



Iceland EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	20.1%	9.1%
Nurses	20.3%	15.4%

Sick leave due to mental health problems

		EU27+ average
Doctors	8.6%	7.4%
Nurses	9.8%	10.5%

Ireland | Country profile

Background

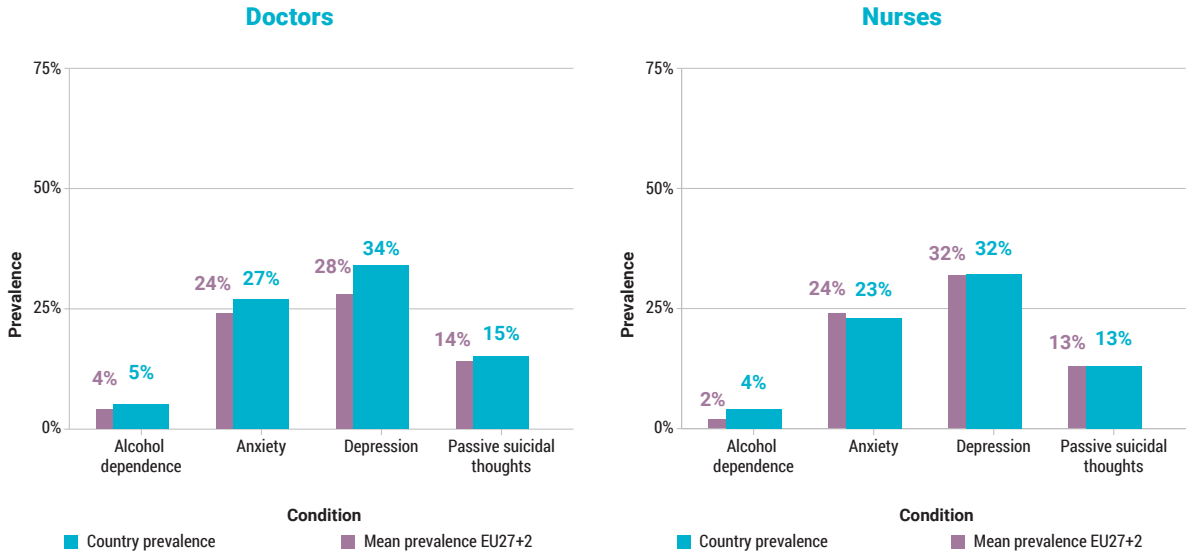
Total country population: **4 994 724**

	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Ireland	153.5	3.6	17.1
EU27+2	123.5	2.2	32.0

Sample characteristics

	number of respondents	proportion of responses in relation to total subgroup population
Female doctors	189	2.0%
Male doctors	136	1.3%
Female nurses	2 495	3.9%
Male nurses	213	2.8%

Prevalence of mental health conditions



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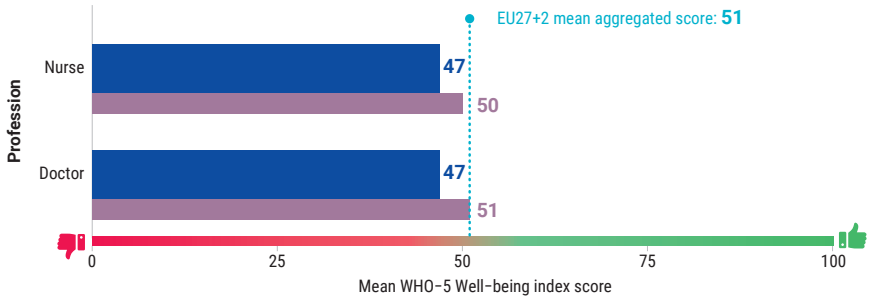
Ireland | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

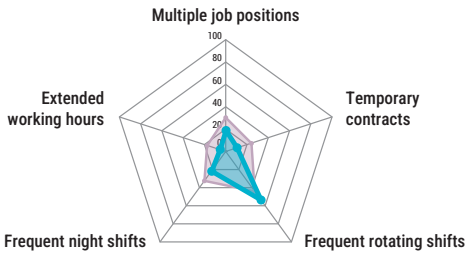
Ireland
EU27+2



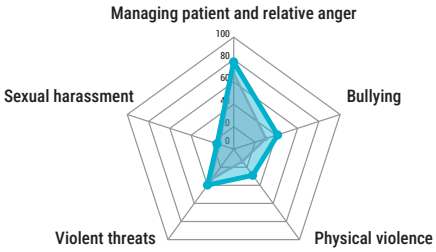
Working conditions

Risk factors

Working hours and contracts

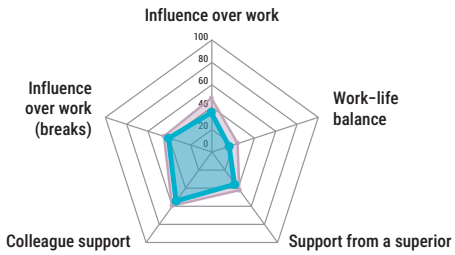


Violence

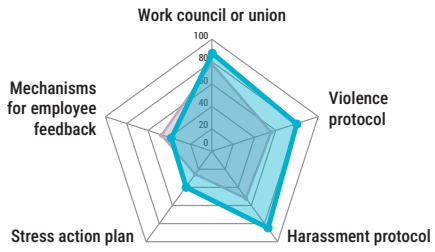


Protective factors

Social support and control



Workplace support structures



Ireland EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	9.4%	9.1%
Nurses	18.1%	15.4%

Sick leave due to mental health problems

		EU27+ average
Doctors	11.0%	7.4%
Nurses	15.0%	10.5%

Italy | Country profile

Background

Total country population: **59 554 023**

	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Italy	106.6	1.6	34.9
EU27+2	123.5	2.2	32.0

Sample characteristics

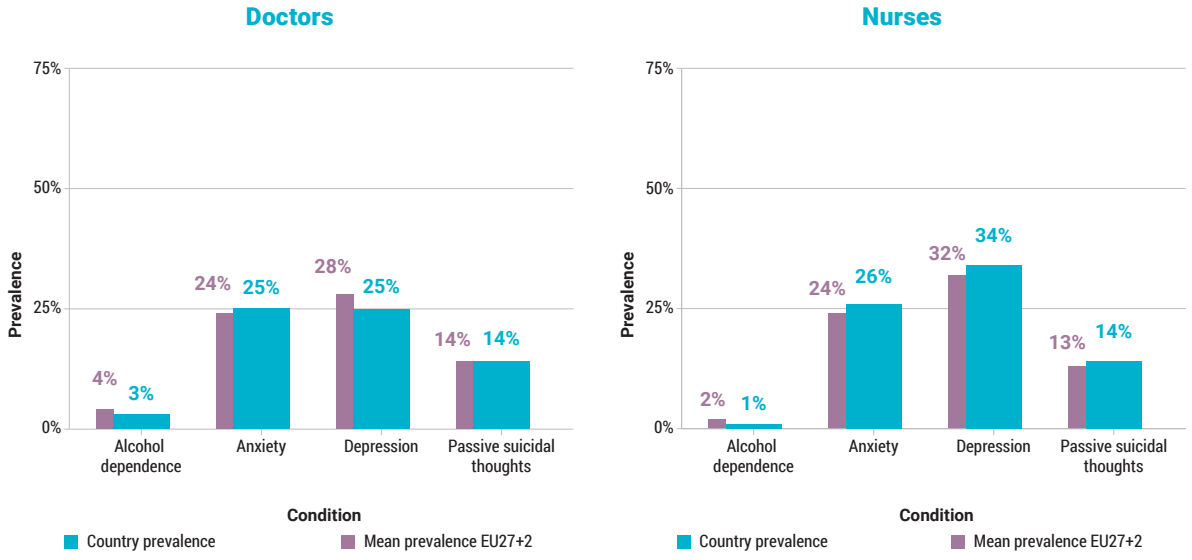
Female doctors
number of respondents: **466**
proportion of responses in relation to total subgroup population: **0.4%**

Male doctors
number of respondents: **350**
proportion of responses in relation to total subgroup population: **0.3%**

Female nurses
number of respondents: **11 793**
proportion of responses in relation to total subgroup population: **4.0%**

Male nurses
number of respondents: **3 095**
proportion of responses in relation to total subgroup population: **3.5%**

Prevalence of mental health conditions



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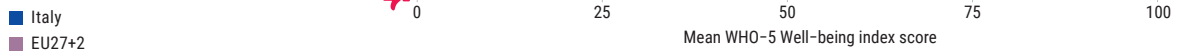
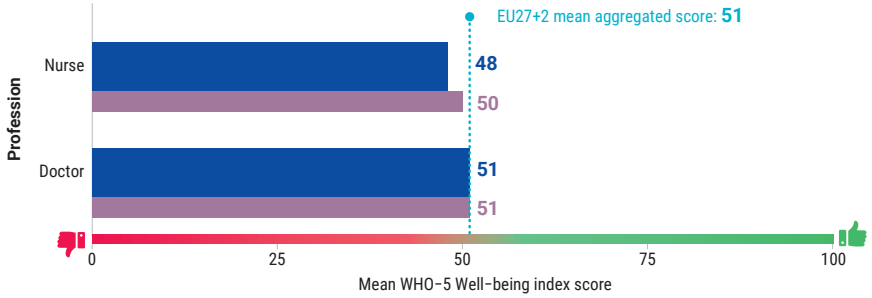
Italy | Country profile

Well-being

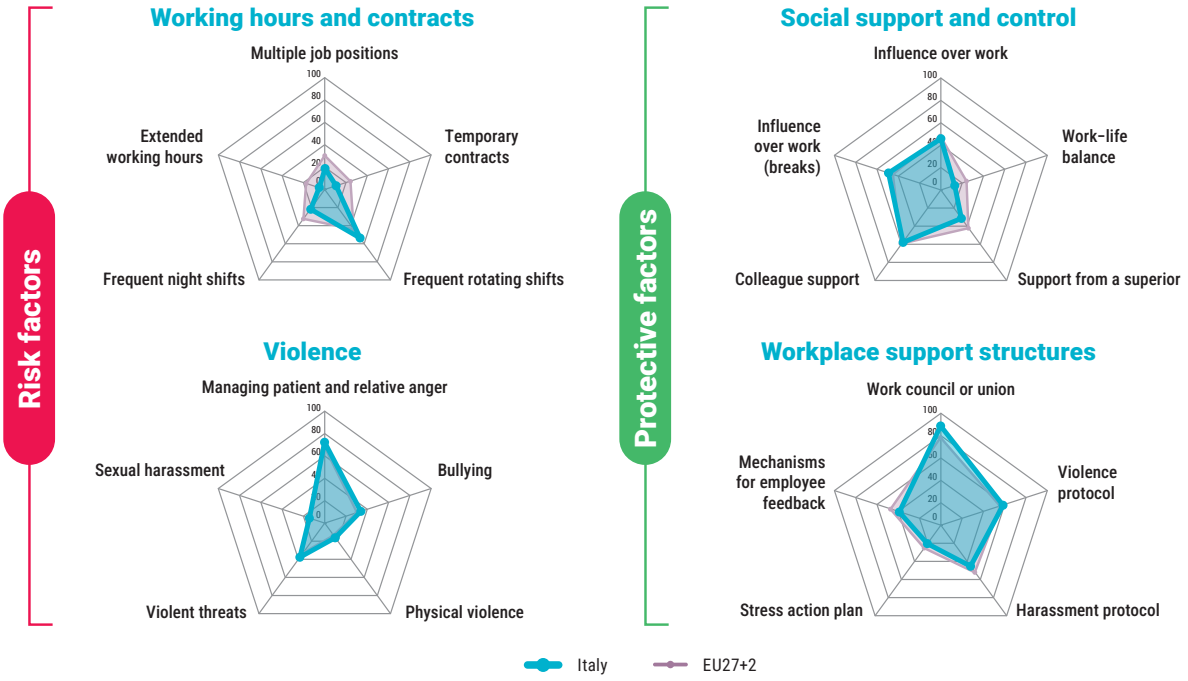
Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.





Working conditions



Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	9.7%	9.1%
Nurses	16.7%	15.4%

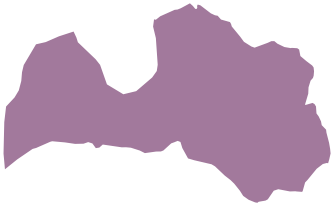
Sick leave due to mental health problems

		EU27+ average
Doctors	2.6%	7.4%
Nurses	6.6%	10.5%

Latvia | Country profile

Background

Total country population: **1 901 548**



	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Latvia	80.0	1.3	41.5
EU27+2	123.5	2.2	32.0

Sample characteristics

Female doctors
number of respondents: **976**
proportion of responses in relation to total subgroup population: **21.2%**

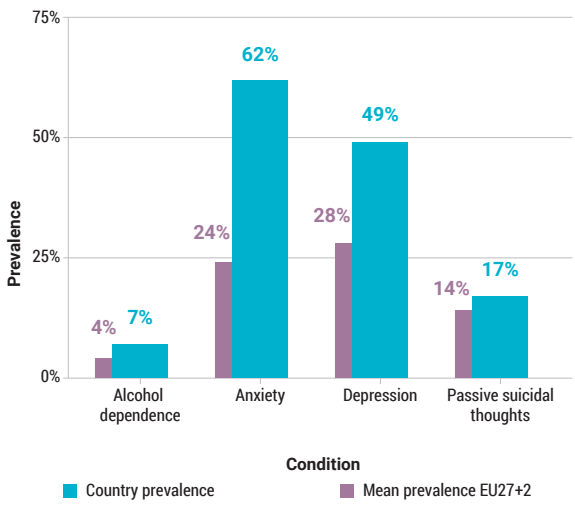
Male doctors
number of respondents: **220**
proportion of responses in relation to total subgroup population: **13.9%**

Female nurses
number of respondents: **1 390**
proportion of responses in relation to total subgroup population: **18.0%**

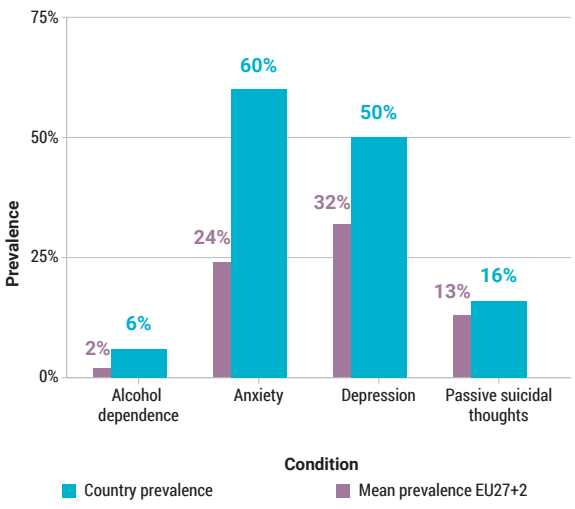
Male nurses
number of respondents: **13**
proportion of responses in relation to total subgroup population: **37.1%**

Prevalence of mental health conditions

Doctors



Nurses



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

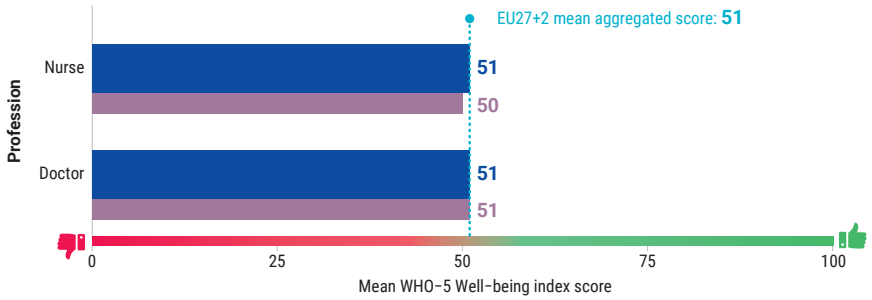
Latvia | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

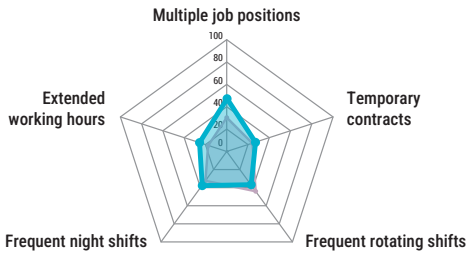
Latvia
EU27+2



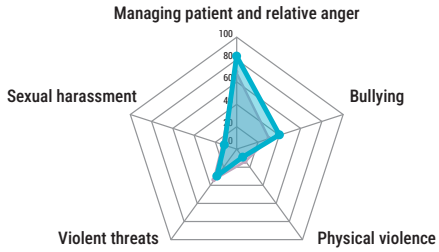
Working conditions

Risk factors

Working hours and contracts

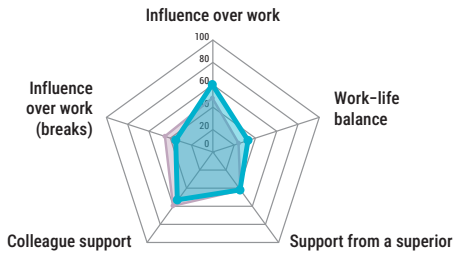


Violence

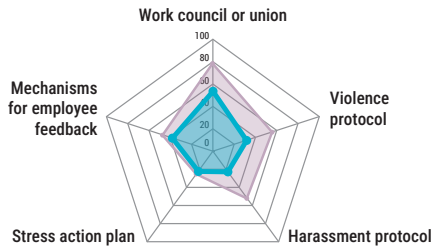


Protective factors

Social support and control



Workplace support structures



Latvia EU27+2

Sick leave and intention to leave

Reported intention to leave profession

	Latvia	EU27+ average
Doctors	7.3%	9.1%
Nurses	8.0%	15.4%

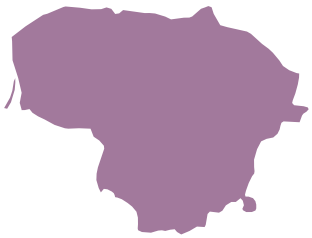
Sick leave due to mental health problems

	Latvia	EU27+ average
Doctors	8.2%	7.4%
Nurses	10.2%	10.5%

Lithuania | Country profile

Background

Total country population: **2 794 700**

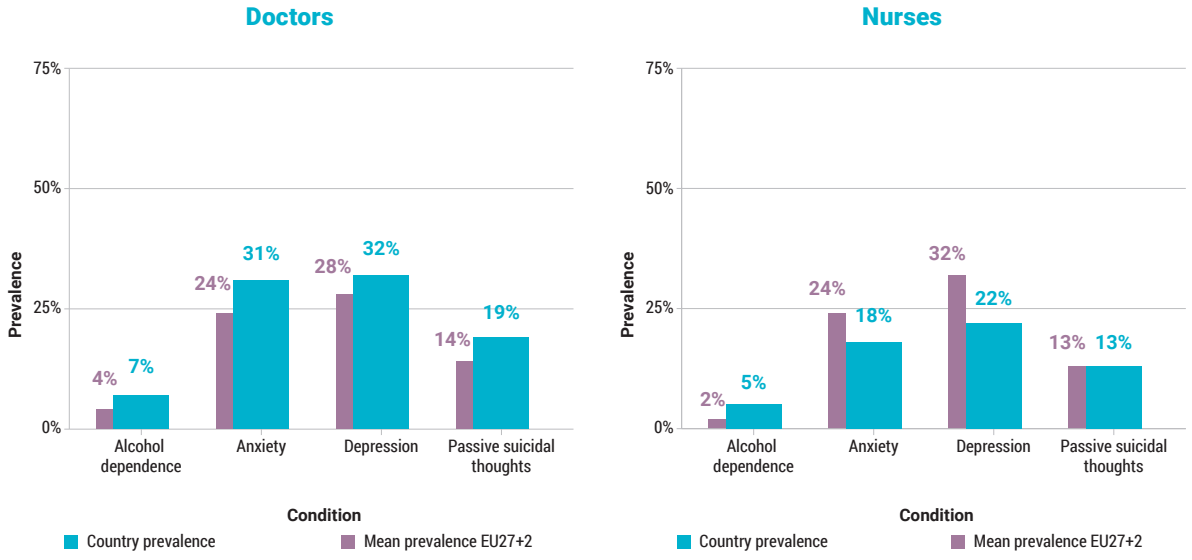


	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Lithuania	121.0	1.7	47.3
EU27+2	123.5	2.2	32.0

Sample characteristics

	number of respondents	proportion of responses in relation to total subgroup population
Female doctors	337	3.9%
Male doctors	85	2.4%
Female nurses	401	1.9%
Male nurses	6	2.4%

Prevalence of mental health conditions



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

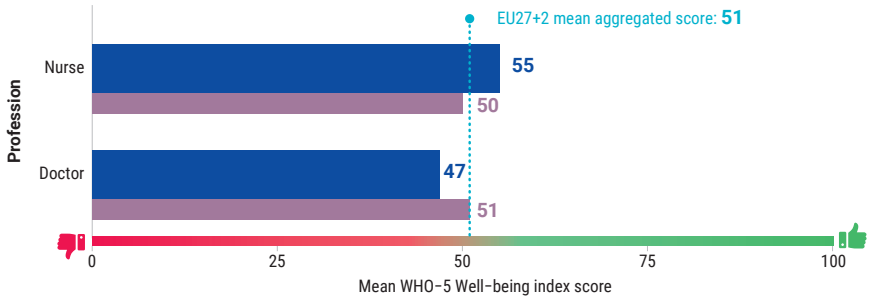
Lithuania | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

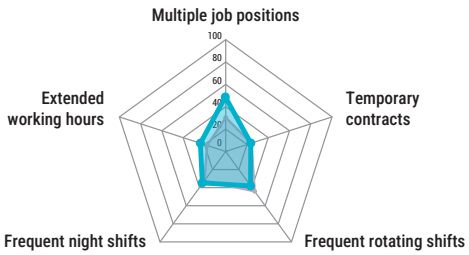
Lithuania
EU27+2



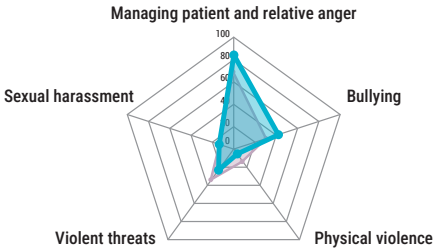
Working conditions

Risk factors

Working hours and contracts

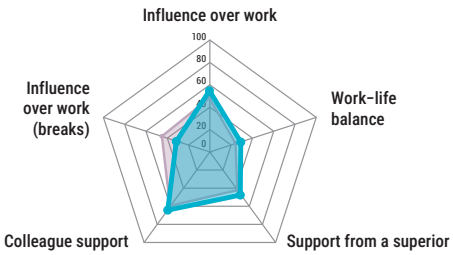


Violence

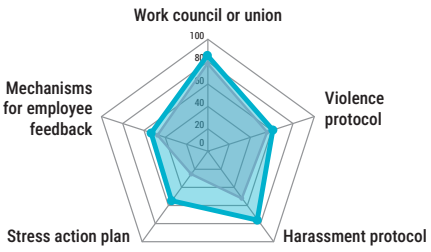


Protective factors

Social support and control



Workplace support structures



Lithuania
EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	7.0%	9.1%
Nurses	13.5%	15.4%

Sick leave due to mental health problems

		EU27+ average
Doctors	3.7%	7.4%
Nurses	2.8%	10.5%

Luxembourg | Country profile

Background

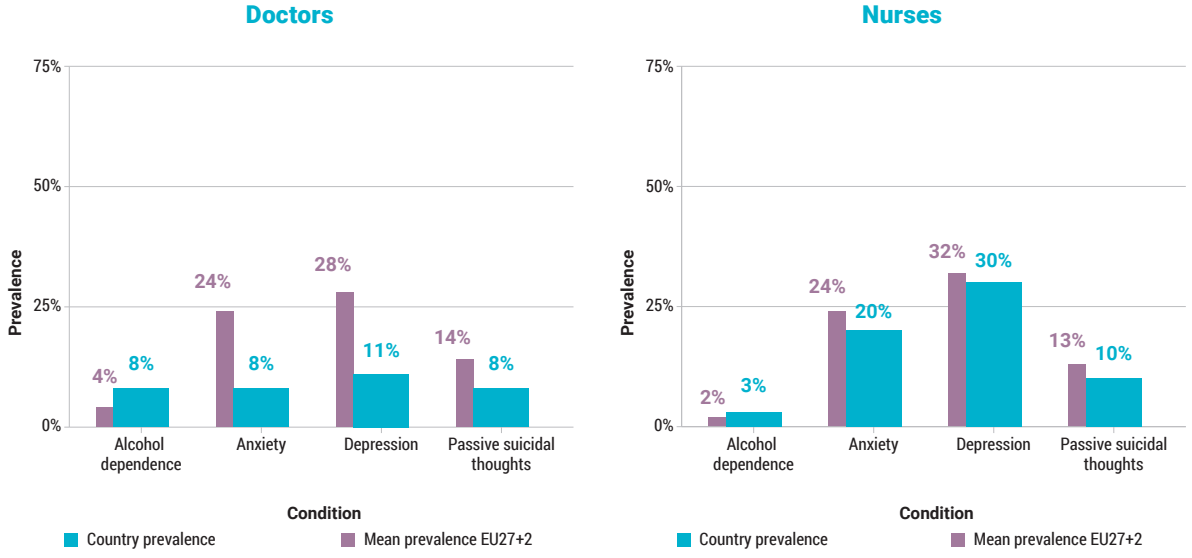
Total country population: **632 275**

	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Luxembourg	147.7	4.2	42.5
EU27+2	123.5	2.2	32.0

Sample characteristics

	number of respondents	proportion of responses in relation to total subgroup population
Female doctors	22	3.5%
Male doctors	18	1.6%
Female nurses	264	N/A
Male nurses	73	N/A

Prevalence of mental health conditions



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

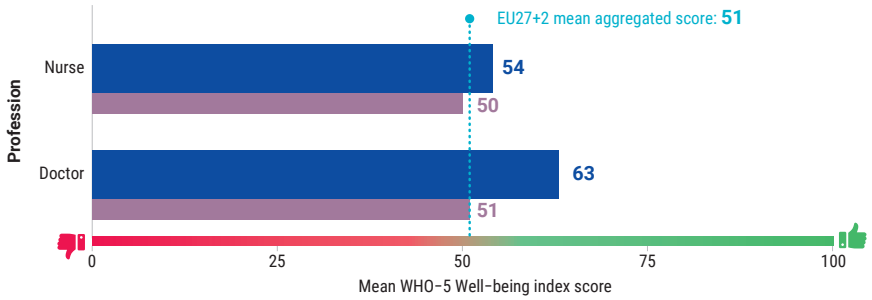
Luxembourg | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

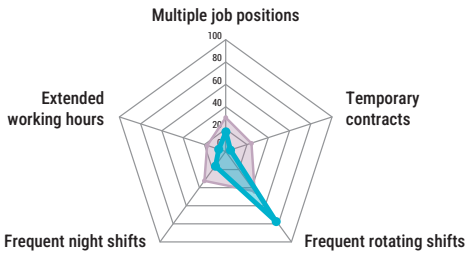
Luxembourg
EU27+2



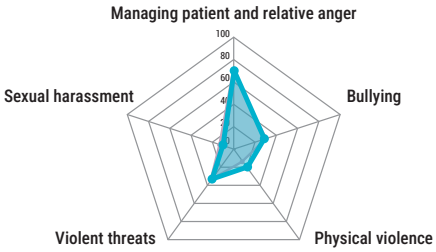
Working conditions

Risk factors

Working hours and contracts

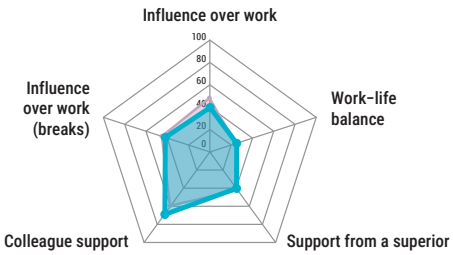


Violence

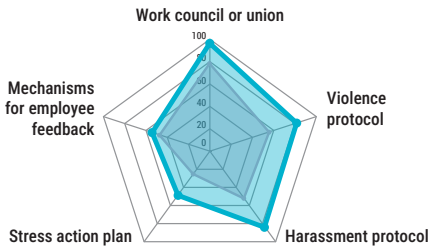


Protective factors

Social support and control



Workplace support structures



Luxembourg
EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	2.6%	9.1%
Nurses	12.1%	15.4%

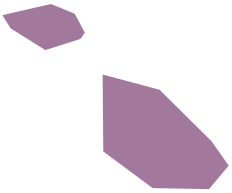
Sick leave due to mental health problems

		EU27+ average
Doctors	13.2%	7.4%
Nurses	8.9%	10.5%

Malta | Country profile

Background

Total country population: **525 285**

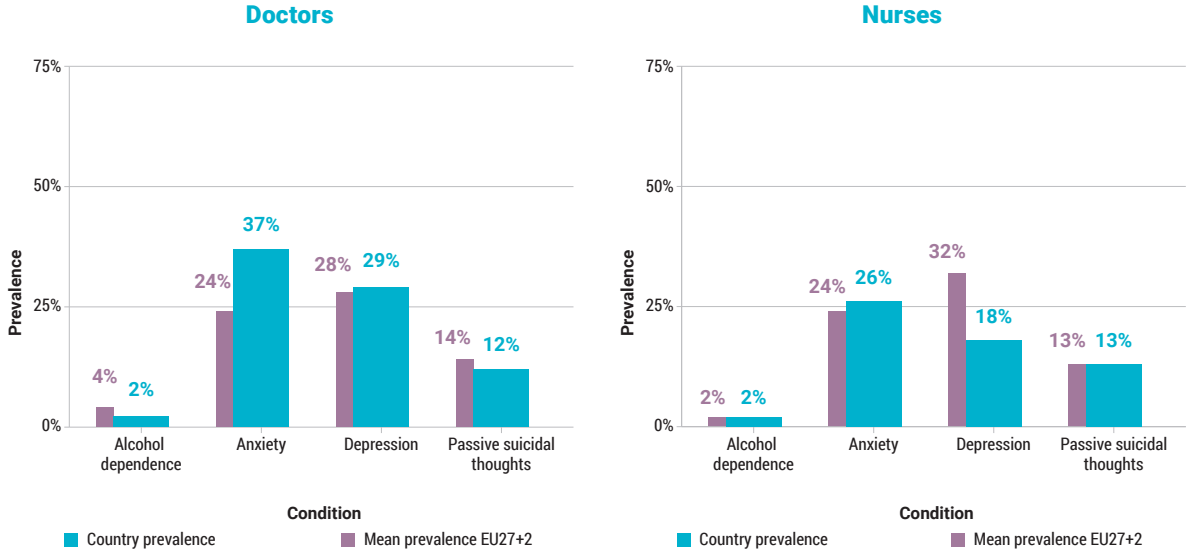


	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Malta	101.5	2.0	20.1
EU27+2	123.5	2.2	32.0

Sample characteristics

	number of respondents	proportion of responses in relation to total subgroup population
Female doctors	**52**	**4.8%**
Male doctors	**52**	**4.1%**
Female nurses	**219**	**N/A**
Male nurses	**102**	**N/A**

Prevalence of mental health conditions



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

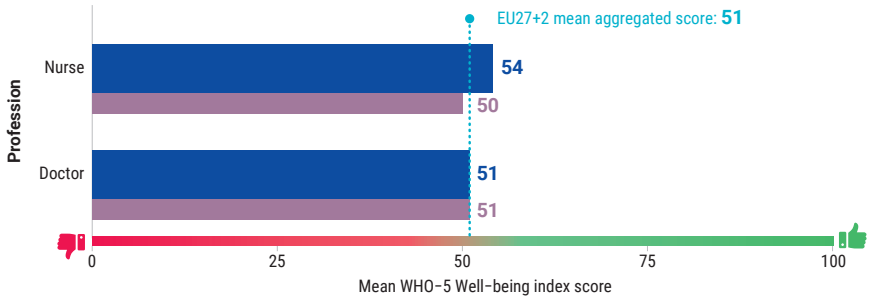
Malta | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

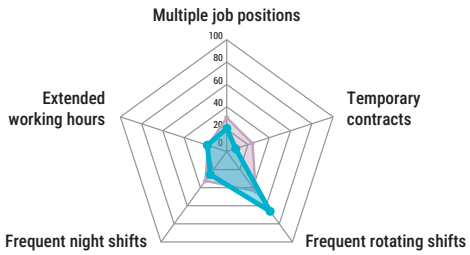
Malta
EU27+2



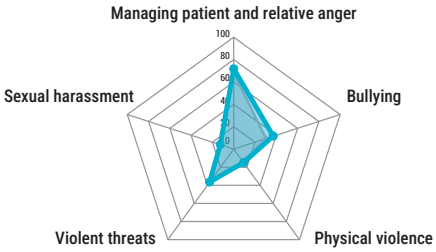
Working conditions

Risk factors

Working hours and contracts

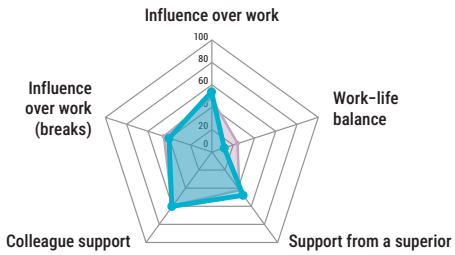


Violence

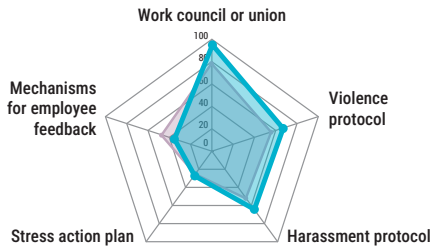


Protective factors

Social support and control



Workplace support structures



Malta
EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	7.4%	9.1%
Nurses	7.3%	15.4%

Sick leave due to mental health problems

		EU27+ average
Doctors	13.5%	7.4%
Nurses	23.1%	10.5%

Netherlands (Kingdom of the)

| Country profile

Background

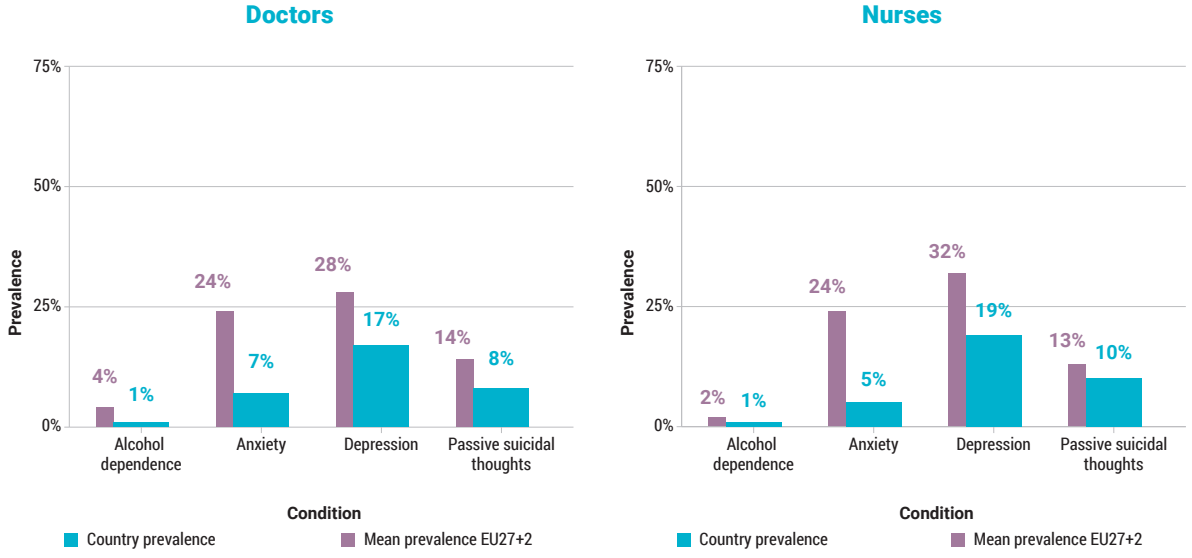
Total country population: **17 441 139**

	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Netherlands (Kingdom of the)	156.8	2.9	23.9
EU27+2	123.5	2.2	32.0

Sample characteristics

	number of respondents	proportion of responses in relation to total subgroup population
Female doctors	152	0.4%
Male doctors	53	0.2%
Female nurses	159	N/A
Male nurses	22	N/A

Prevalence of mental health conditions



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

Netherlands
(Kingdom of the)

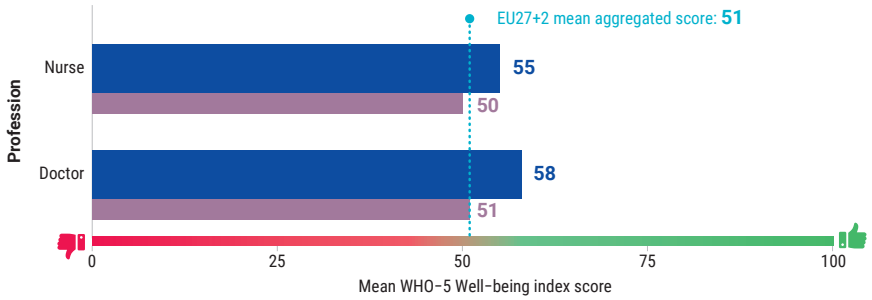
Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

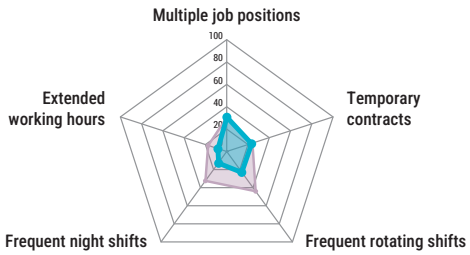
Netherlands
EU27+2



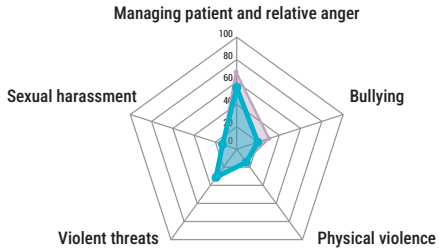
Working conditions

Risk factors

Working hours and contracts

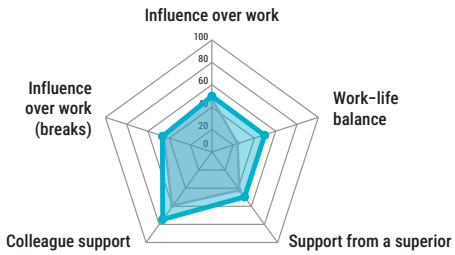


Violence

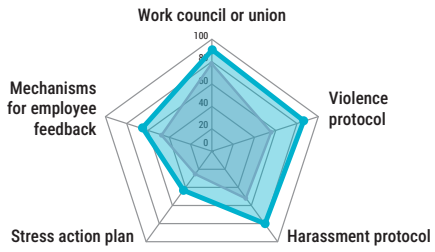


Protective factors

Social support and control



Workplace support structures



Netherlands
EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	10.8%	9.1%
Nurses	17.9%	15.4%

Sick leave due to mental health problems

		EU27+ average
Doctors	12.6%	7.4%
Nurses	18.1%	10.5%

Norway | Country profile

Background

Total country population: **5 379 475**

	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Norway	209.7	3.9	23.8
EU27+2	123.5	2.2	32.0

Sample characteristics

Female doctors
number of respondents: **1 005**
proportion of responses in relation to total subgroup population: **6.9%**

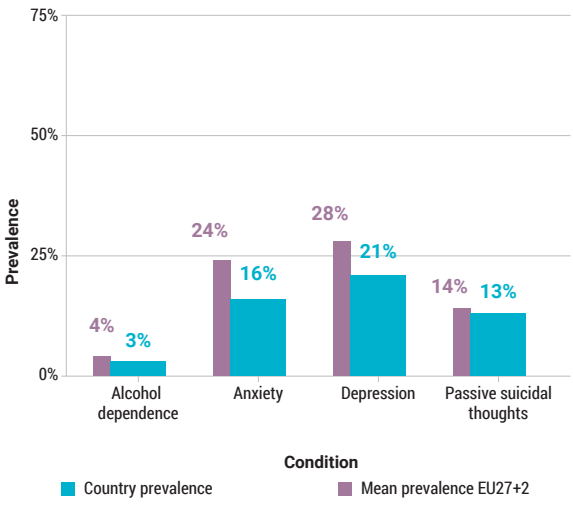
Male doctors
number of respondents: **742**
proportion of responses in relation to total subgroup population: **5.6%**

Female nurses
number of respondents: **176**
proportion of responses in relation to total subgroup population: **N/A**

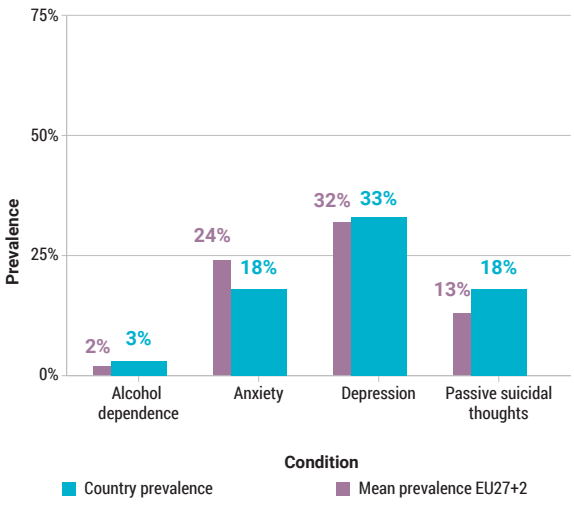
Male nurses
number of respondents: **21**
proportion of responses in relation to total subgroup population: **N/A**

Prevalence of mental health conditions

Doctors



Nurses



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

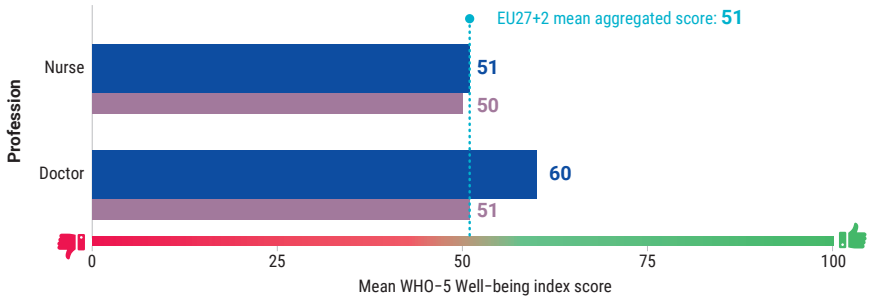
Norway | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

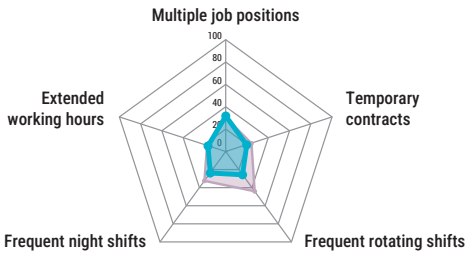
Norway
EU27+2



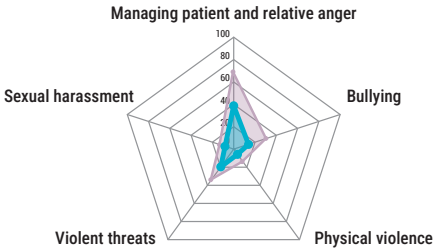
Working conditions

Risk factors

Working hours and contracts

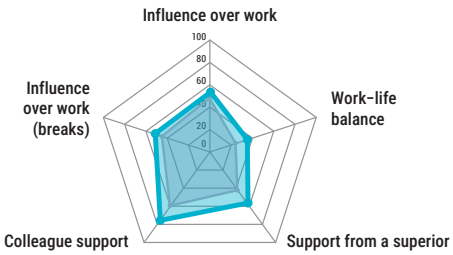


Violence

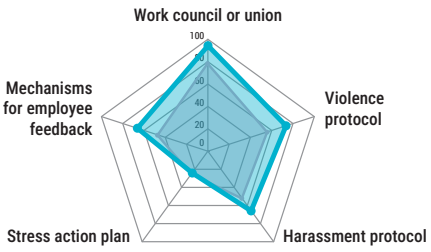


Protective factors

Social support and control



Workplace support structures



Norway
EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	11.9%	9.1%
Nurses	23.6%	15.4%

Sick leave due to mental health problems

		EU27+ average
Doctors	9.7%	7.4%
Nurses	17.0%	10.5%

Poland | Country profile

Background

Total country population: **37 950 802**

	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Poland	74.0	2.4	37.9
EU27+2	123.5	2.2	32.0

Sample characteristics

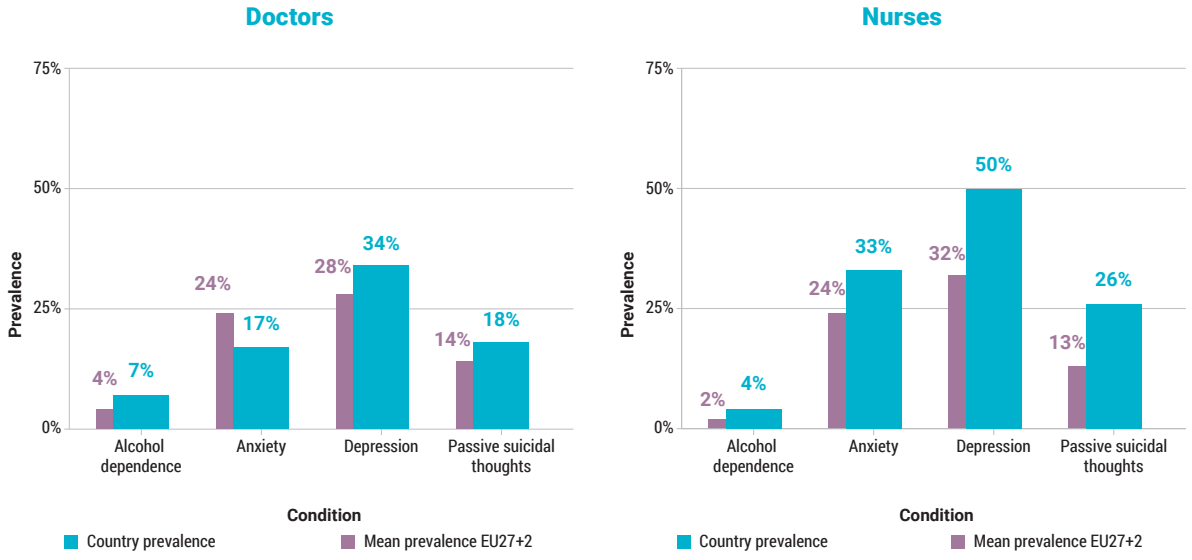
Female doctors — number of respondents: **53**; proportion of responses in relation to total subgroup population: **0.1%**

Male doctors — number of respondents: **35**; proportion of responses in relation to total subgroup population: **0.1%**

Female nurses — number of respondents: **1 871**; proportion of responses in relation to total subgroup population: **N/A**

Male nurses — number of respondents: **119**; proportion of responses in relation to total subgroup population: **N/A**

Prevalence of mental health conditions



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

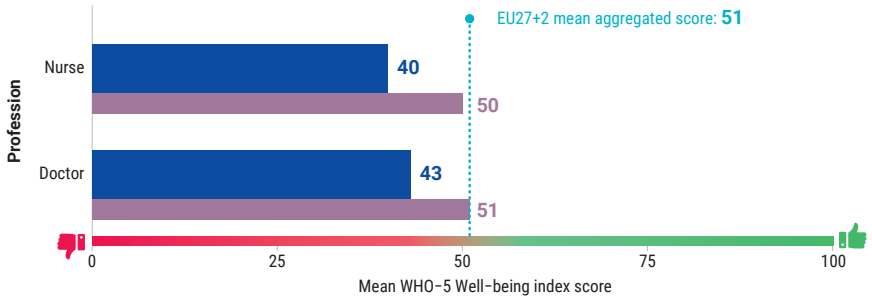
Poland | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

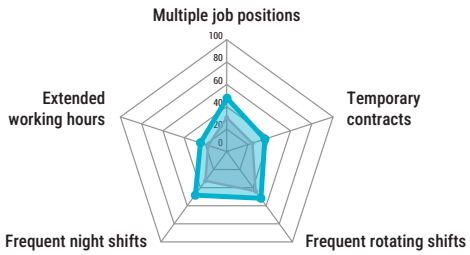
Poland
EU27+2



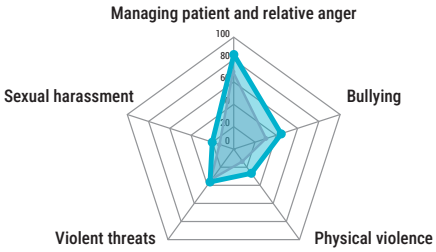
Working conditions

Risk factors

Working hours and contracts

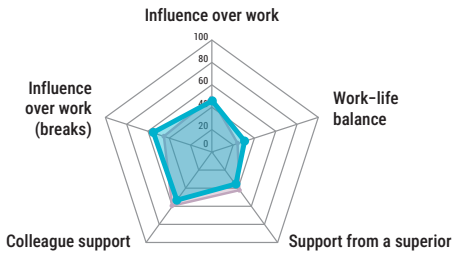


Violence

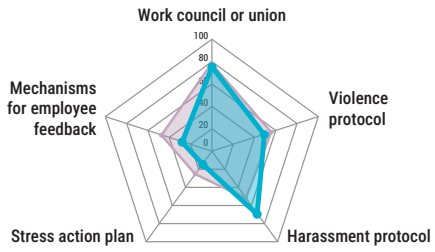


Protective factors

Social support and control



Workplace support structures



Poland
EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	9.0%	9.1%
Nurses	11.1%	15.4%

Sick leave due to mental health problems

		EU27+ average
Doctors	4.1%	7.4%
Nurses	10.4%	10.5%

Portugal | Country profile

Background

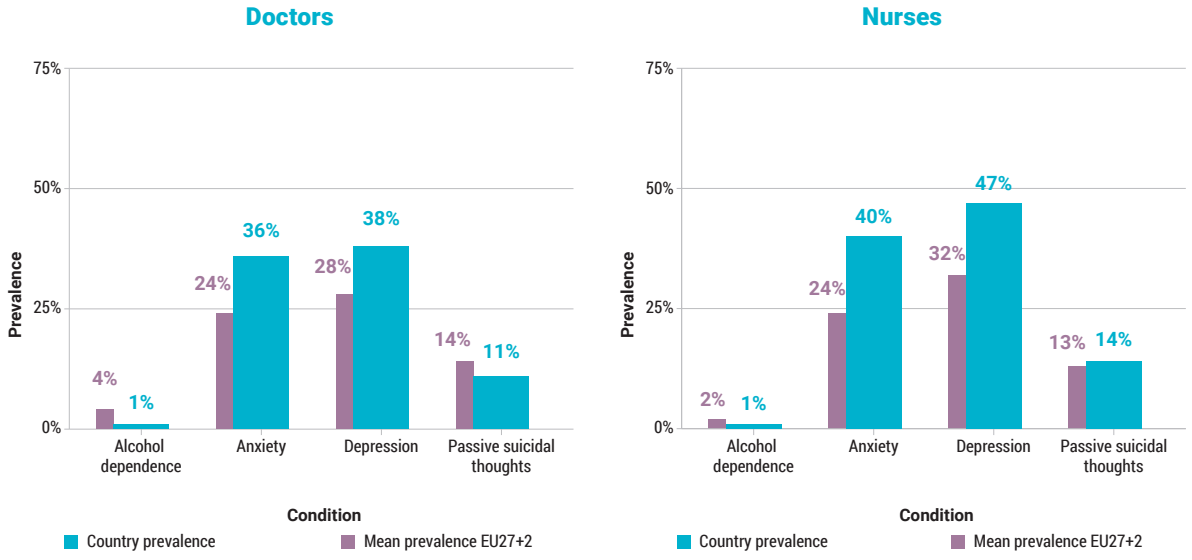
Total country population: **10 305 564**

	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Portugal	103.1	1.4	
EU27+2	123.5	2.2	32.0

Sample characteristics

	number of respondents	proportion of responses in relation to total subgroup population
Female doctors	568	N/A
Male doctors	182	N/A
Female nurses	1778	N/A
Male nurses	300	N/A

Prevalence of mental health conditions



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

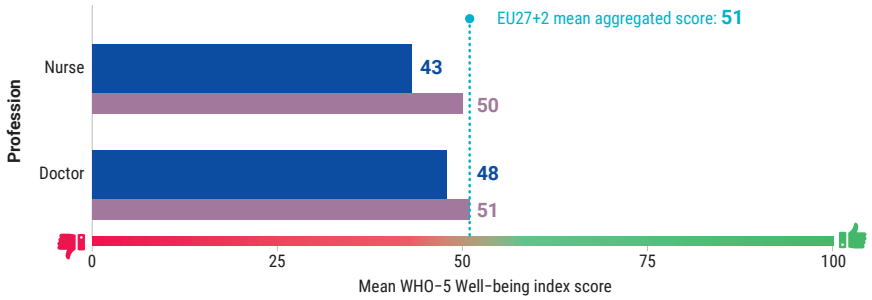
Portugal | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

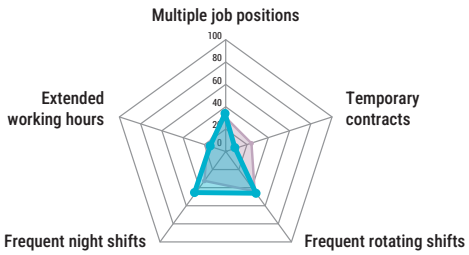
Portugal
EU27+2



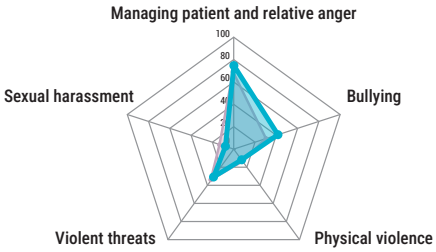
Working conditions

Risk factors

Working hours and contracts

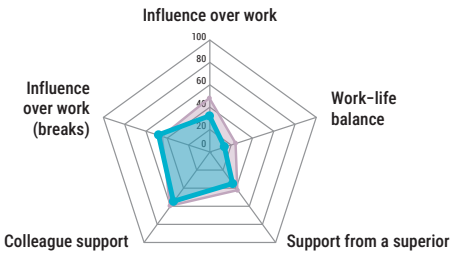


Violence

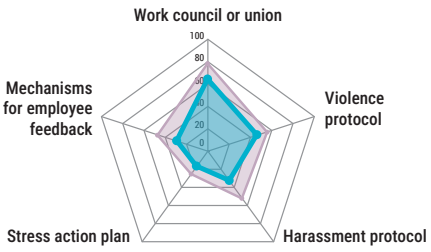


Protective factors

Social support and control



Workplace support structures



Portugal
EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	4.6%	9.1%
Nurses	12.9%	15.4%

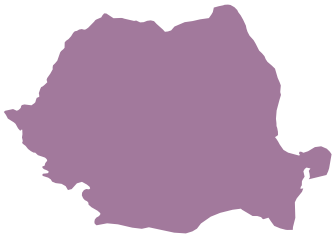
Sick leave due to mental health problems

		EU27+ average
Doctors	11.4%	7.4%
Nurses	13.5%	10.5%

Romania | Country profile

Background

Total country population: **19 286 123**



	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Romania	86.2	0.3	18.6
EU27+2	123.5	2.2	32.0

Sample characteristics

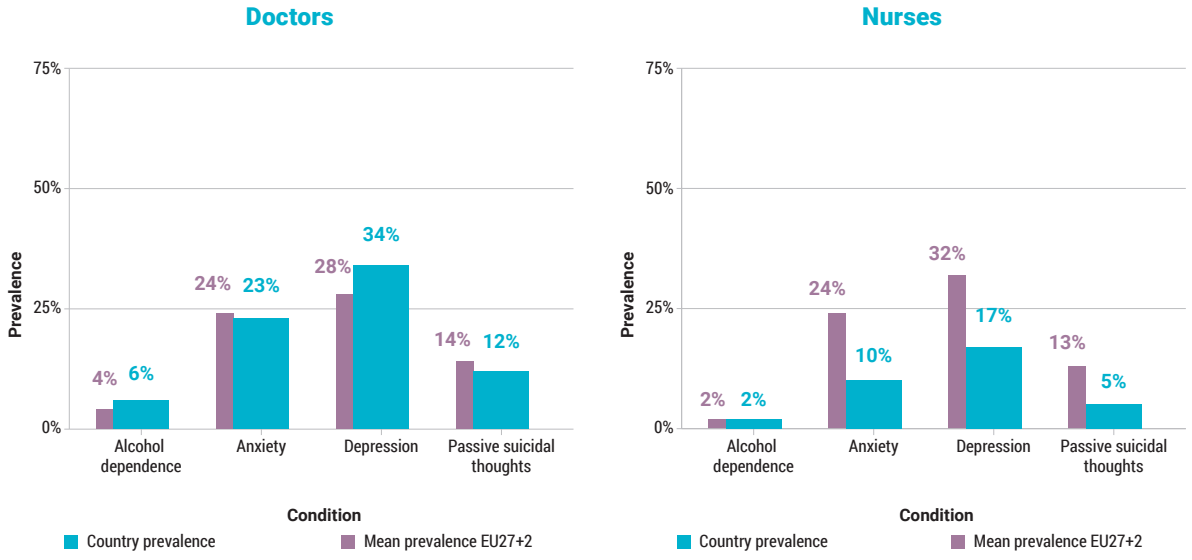
Female doctors
number of respondents: **2 218**
proportion of responses in relation to total subgroup population: **4.5%**

Male doctors
number of respondents: **783**
proportion of responses in relation to total subgroup population: **3.9%**

Female nurses
number of respondents: **2 778**
proportion of responses in relation to total subgroup population: **17.1%**

Male nurses
number of respondents: **254**
proportion of responses in relation to total subgroup population: **16.4%**

Prevalence of mental health conditions



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

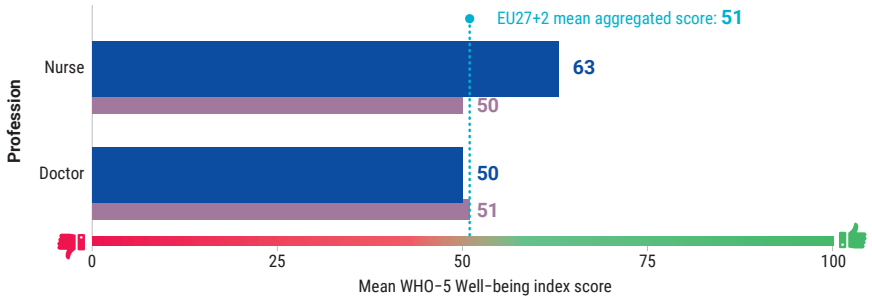
Romania | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

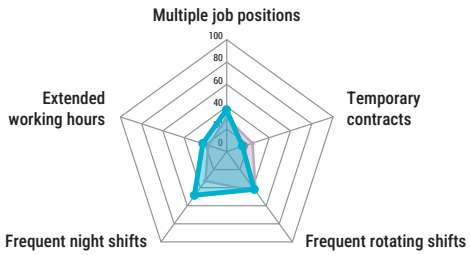
Romania
EU27+2



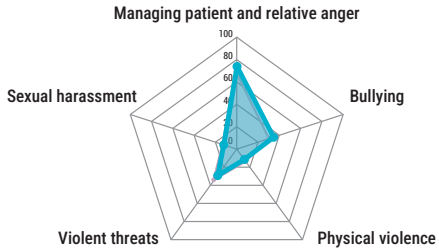
Working conditions

Risk factors

Working hours and contracts

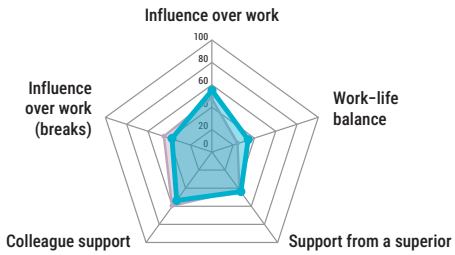


Violence

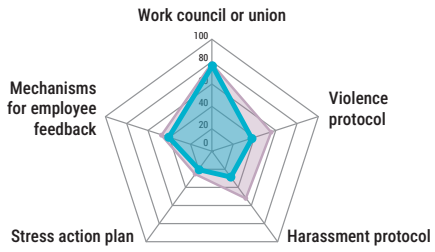


Protective factors

Social support and control



Workplace support structures



Romania
EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	6.1%	9.1%
Nurses	7.5%	15.4%

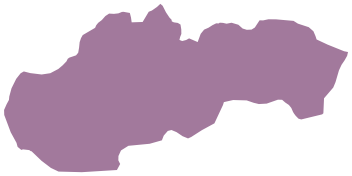
Sick leave due to mental health problems

		EU27+ average
Doctors	3.4%	7.4%
Nurses	2.3%	10.5%

Slovakia | Country profile

Background

Total country population: **5 458 827**

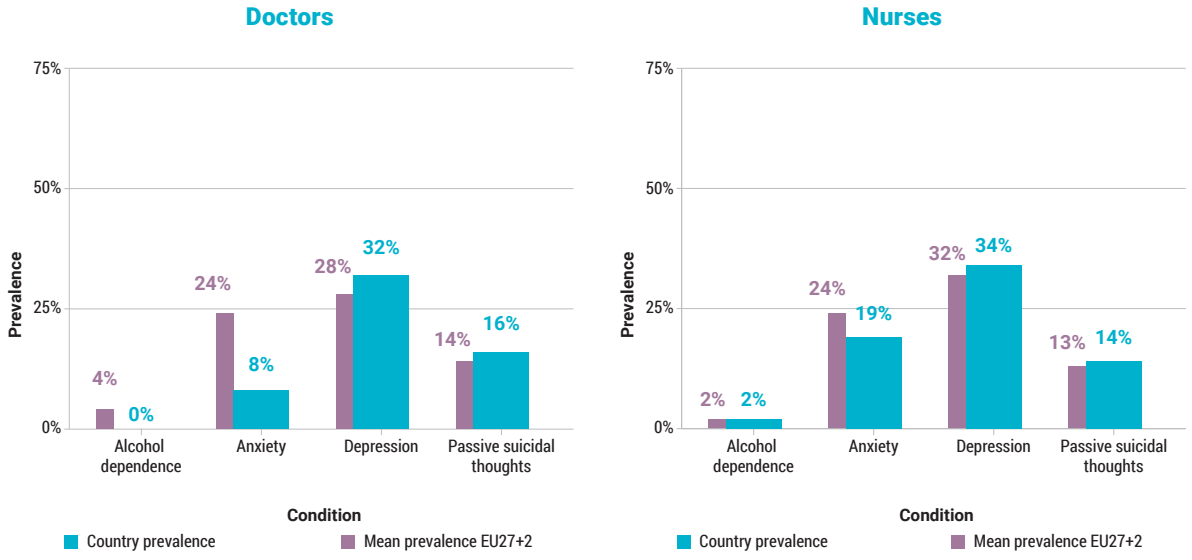


	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Slovakia	91.4	1.7	33.2
EU27+2	123.5	2.2	32.0

Sample characteristics

	number of respondents	proportion of responses in relation to total subgroup population
Female doctors	12	0.1%
Male doctors	17	0.2%
Female nurses	517	N/A
Male nurses	36	N/A

Prevalence of mental health conditions



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

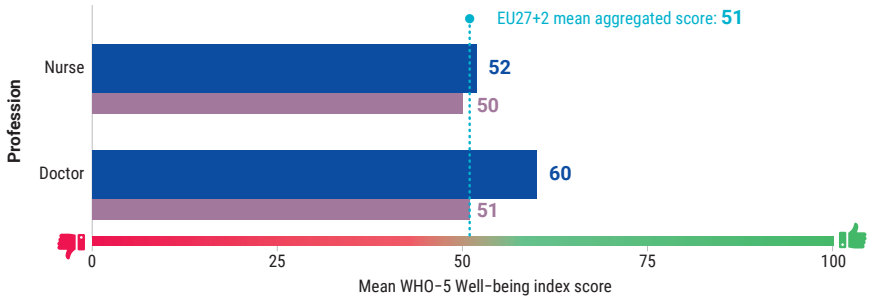
Slovakia | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

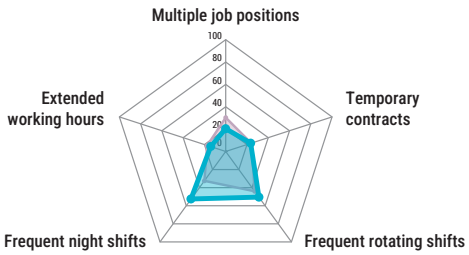
Slovakia
EU27+2



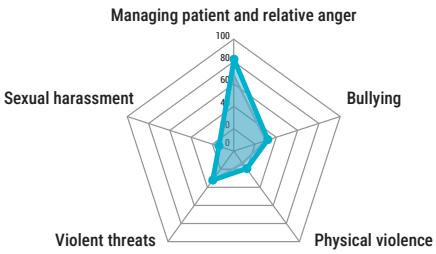
Working conditions

Risk factors

Working hours and contracts

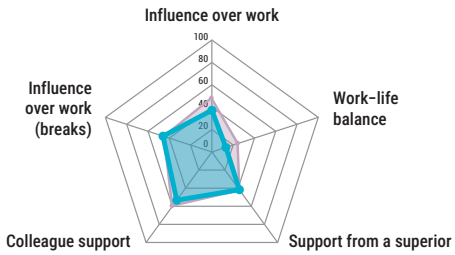


Violence

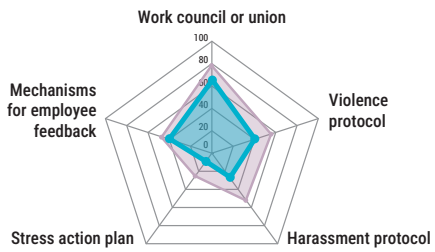


Protective factors

Social support and control



Workplace support structures



Slovakia
EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	12.0%	9.1%
Nurses	16.2%	15.4%

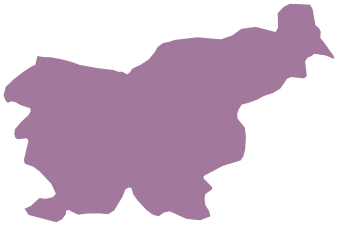
Sick leave due to mental health problems

		EU27+ average
Doctors	0.0%	7.4%
Nurses	3.4%	10.5%

Slovenia | Country profile

Background

Total country population: **2 100 126**



	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Slovenia	138.9	1.5	21.2
EU27+2	123.5	2.2	32.0

Sample characteristics

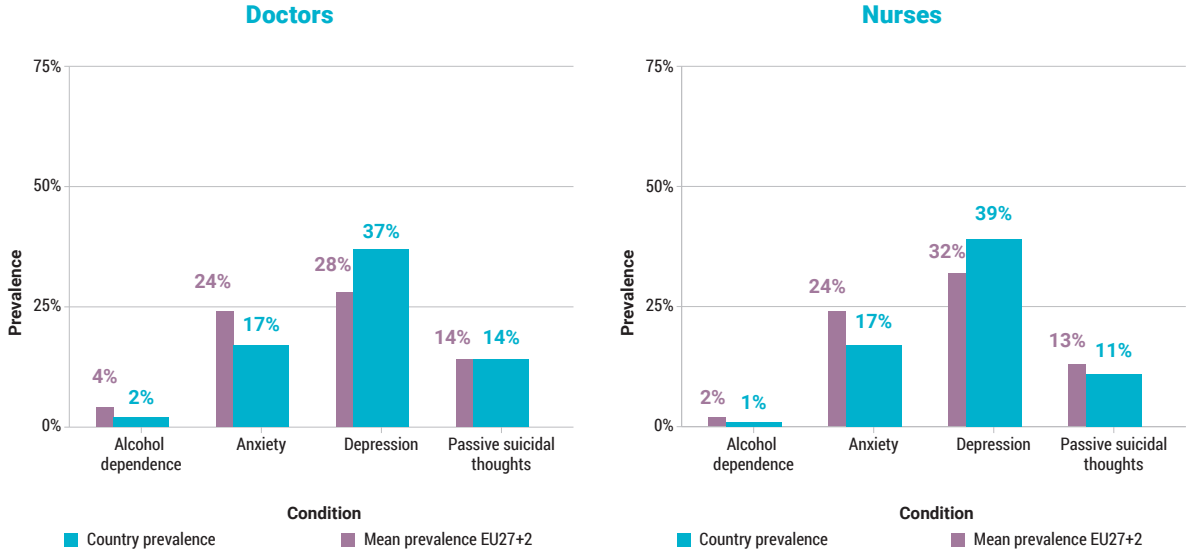
Female doctors
number of respondents: **976**
proportion of responses in relation to total subgroup population: **21.5%**

Male doctors
number of respondents: **337**
proportion of responses in relation to total subgroup population: **13.3%**

Female nurses
number of respondents: **815**
proportion of responses in relation to total subgroup population: **9.1%**

Male nurses
number of respondents: **80**
proportion of responses in relation to total subgroup population: **5.6%**

Prevalence of mental health conditions



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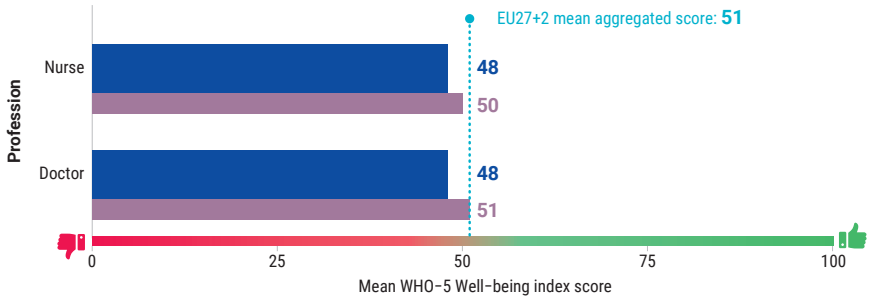
Slovenia | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

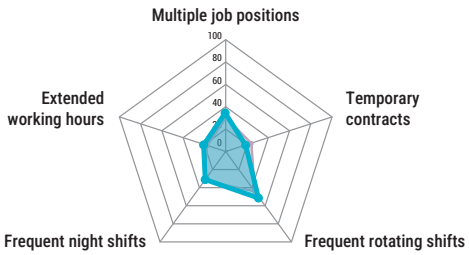
Slovenia
EU27+2



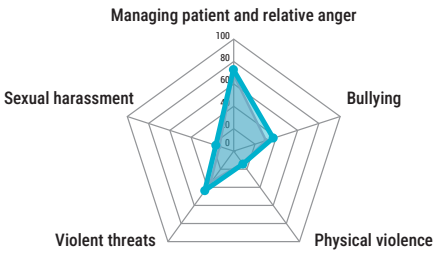
Working conditions

Risk factors

Working hours and contracts

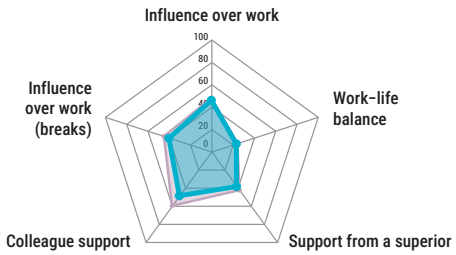


Violence

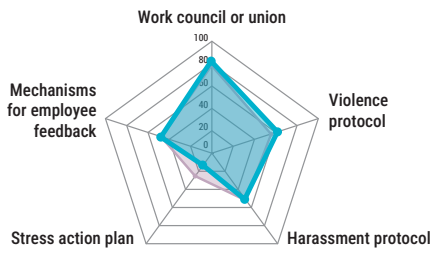


Protective factors

Social support and control



Workplace support structures



Slovenia
EU27+2

Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	10.5%	9.1%
Nurses	18.7%	15.4%

Sick leave due to mental health problems

		EU27+ average
Doctors	7.2%	7.4%
Nurses	9.9%	10.5%

Spain | Country profile

Background

Total country population: **47 351 567**

	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Spain	89.6	1.4	25.1
EU27+2	123.5	2.2	32.0

Sample characteristics

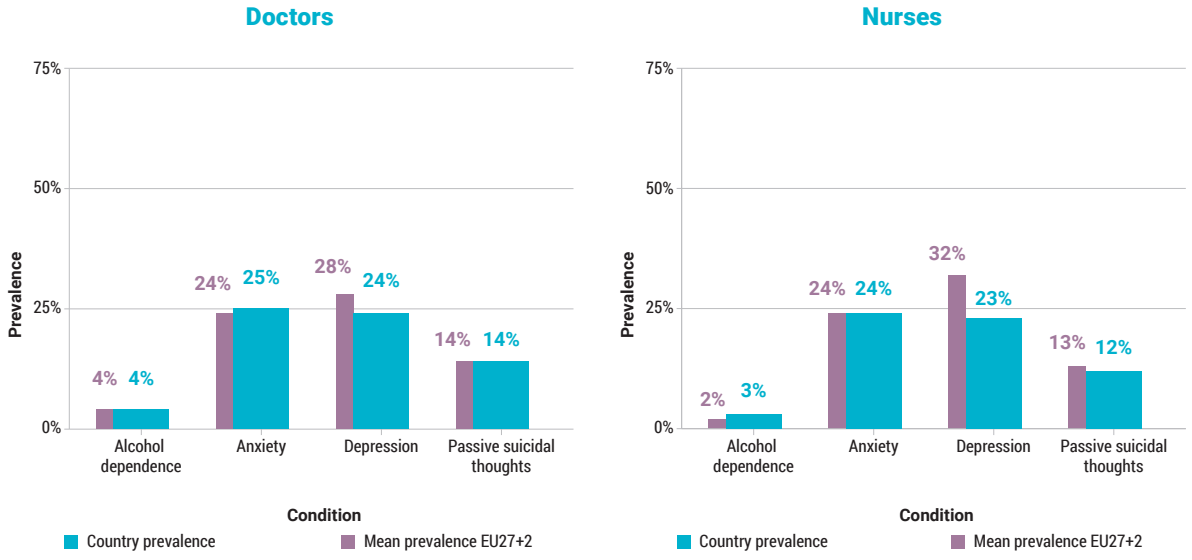
Female doctors
number of respondents: **5 201**
proportion of responses in relation to total subgroup population: **4.3%**

Male doctors
number of respondents: **2 508**
proportion of responses in relation to total subgroup population: **2.9%**

Female nurses
number of respondents: **4 653**
proportion of responses in relation to total subgroup population: **1.9%**

Male nurses
number of respondents: **854**
proportion of responses in relation to total subgroup population: **2.0%**

Prevalence of mental health conditions



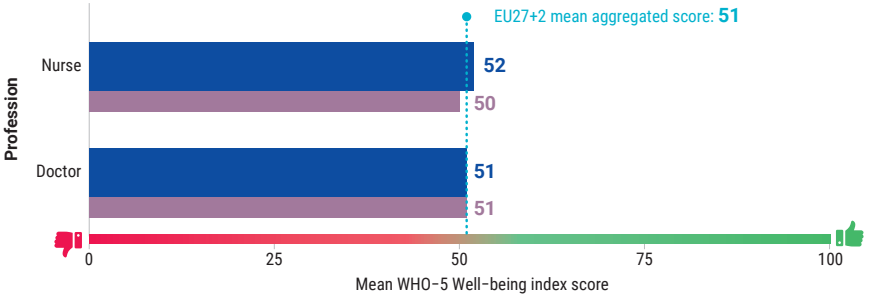
Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

Spain | Country profile

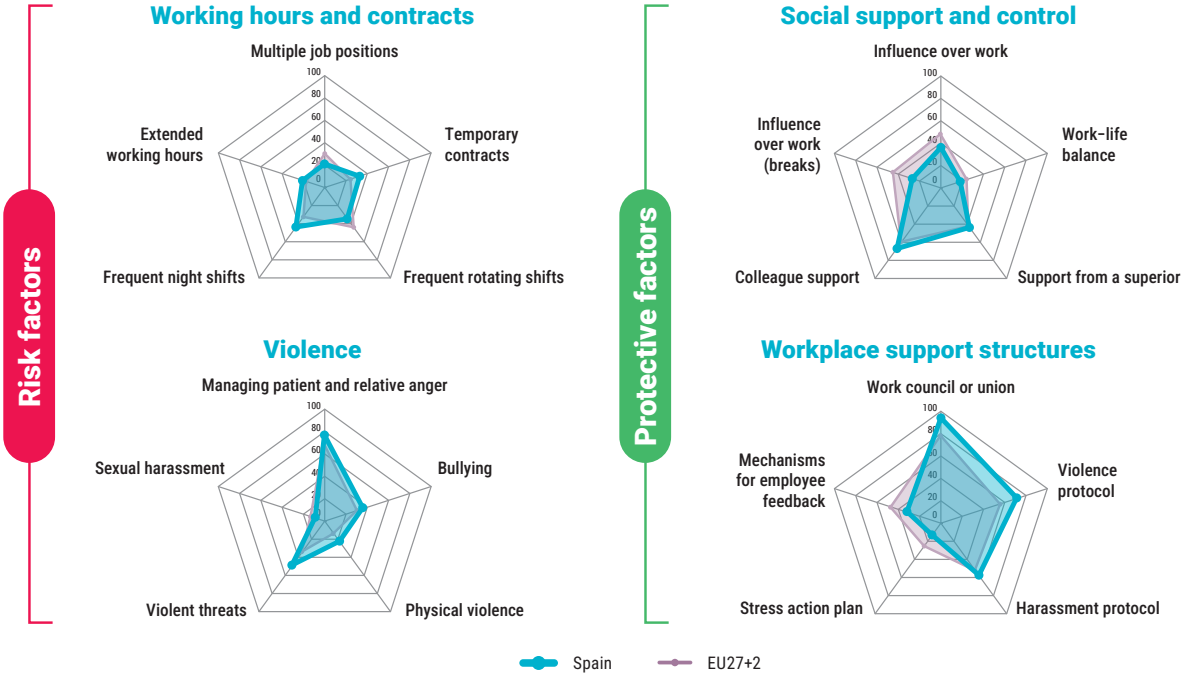
Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.



Working conditions



Sick leave and intention to leave

Reported intention to leave profession

		EU27+ average
Doctors	8.8%	9.1%
Nurses	10.9%	15.4%

Sick leave due to mental health problems

		EU27+ average
Doctors	7.3%	7.4%
Nurses	11.0%	10.5%

Sweden | Country profile

Background

Total country population: **10 353 442**

	Doctors and nurses per 10 000 population	Nurse to doctor ratio	Aged 55 years and older (%)
Sweden	149.2	2.7	26.4
EU27+2	123.5	2.2	32.0

Sample characteristics

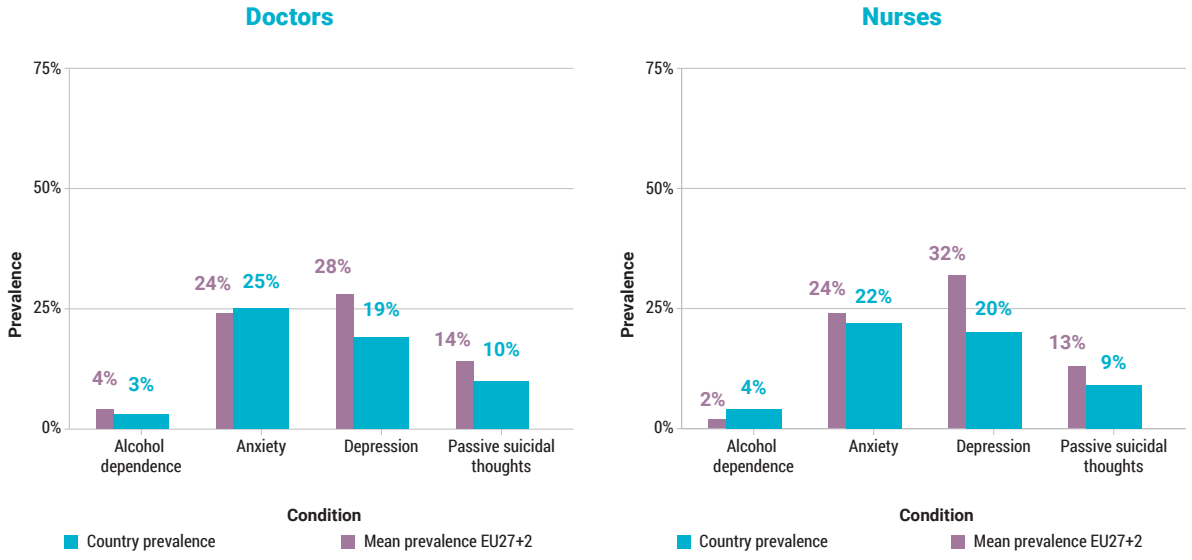
Female doctors
number of respondents: **596**
proportion of responses in relation to total subgroup population: **2.5%**

Male doctors
number of respondents: **207**
proportion of responses in relation to total subgroup population: **0.9%**

Female nurses
number of respondents: **717**
proportion of responses in relation to total subgroup population: **N/A**

Male nurses
number of respondents: **77**
proportion of responses in relation to total subgroup population: **N/A**

Prevalence of mental health conditions



Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

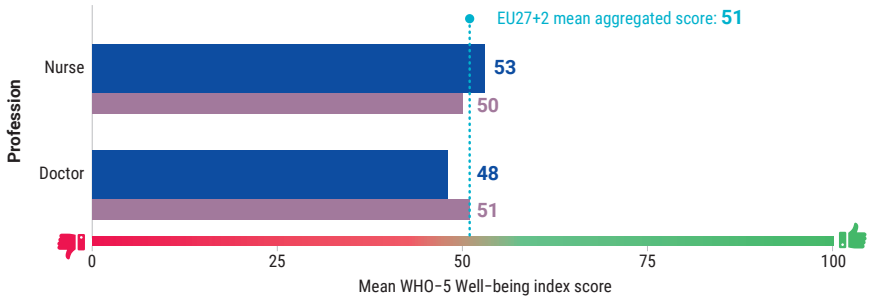
Sweden | Country profile

Well-being

Mean emotional well-being scores by profession

The scale ranges from 0 to 100, with a score above 50 being perceived as good well-being.

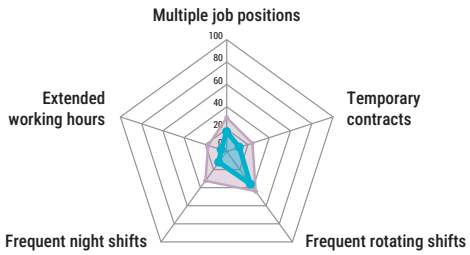
Sweden
EU27+2



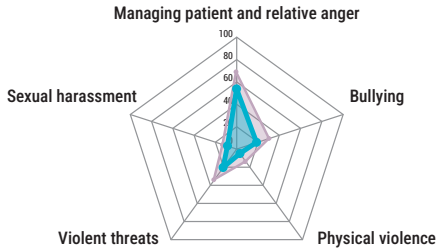
Working conditions

Risk factors

Working hours and contracts

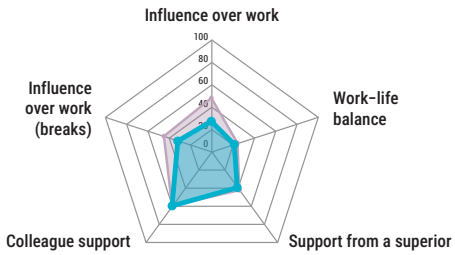


Violence

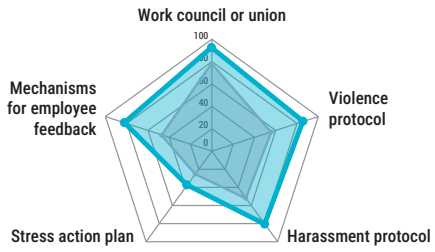


Protective factors

Social support and control



Workplace support structures



Sweden
EU27+2

Sick leave and intention to leave

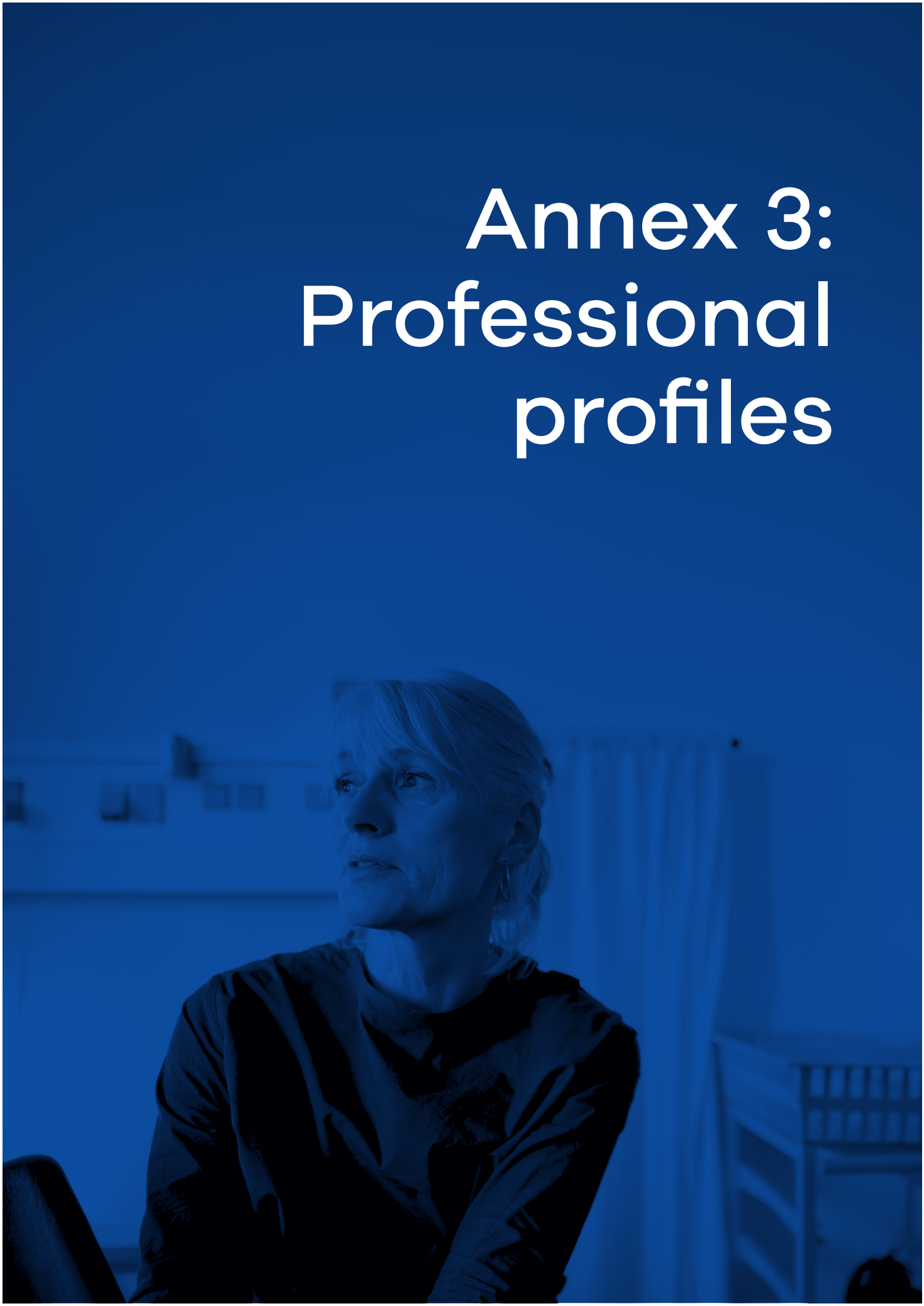
Reported intention to leave profession

		EU27+ average
Doctors	11.5%	9.1%
Nurses	10.8%	15.4%

Sick leave due to mental health problems

		EU27+ average
Doctors	10.4%	7.4%
Nurses	9.6%	10.5%

Annex 3: Professional profiles



Nurse
Professional profile

Sample characteristics

Number of female respondents

44 822 86.7%

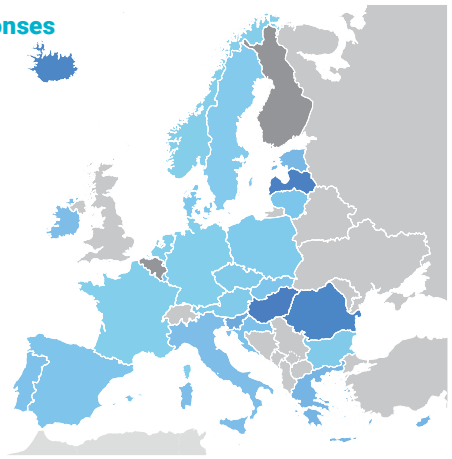
Number of male respondents

6 880 13.3%

Number of respondents aged 55+

11 917 22.7%

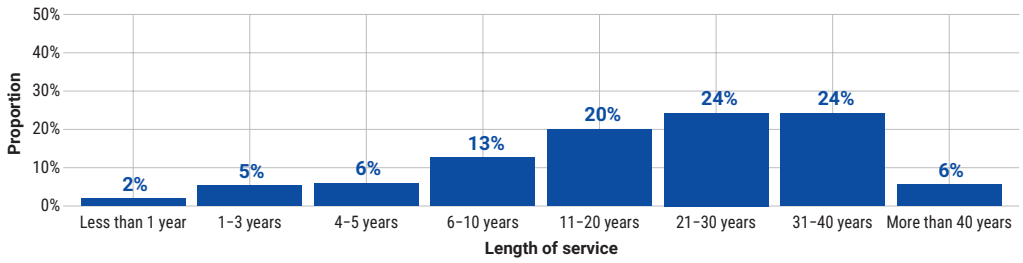
Proportion of responses by total number of nurses



Proportion of responses below 1% in Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland.

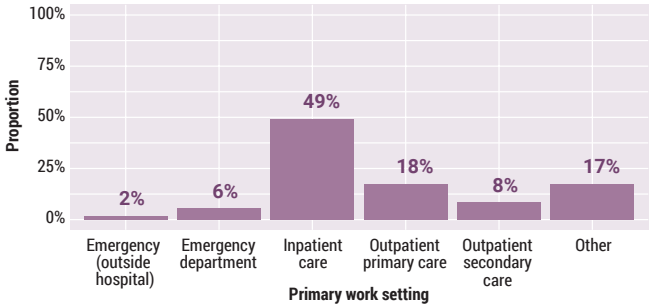
Belgium and Finland in grey as no official data on total professionals was available.

Length of service

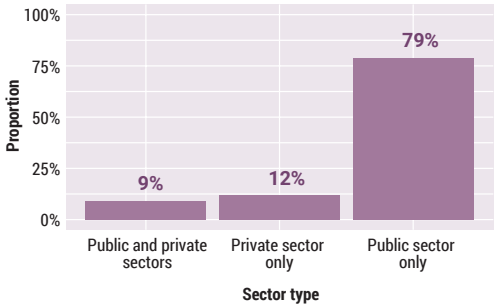


Setting and sector

Primary work setting distribution



Health sector distribution



Prevalence of mental health conditions

	Depression	Anxiety	Alcohol dependence	Passive suicidal thoughts
Female	32.6%	24.2%	2.0%	12.6%
Male	29.2%	21.5%	4.2%	15.2%
Total	32.2%	23.8%	2.2%	13.0%

Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

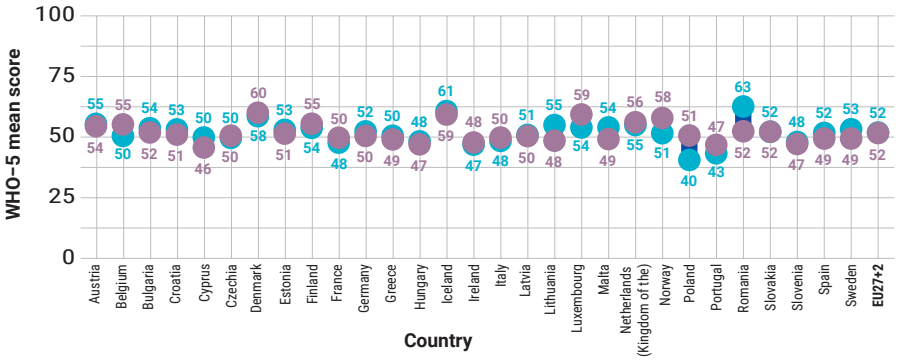
Nurse
Professional profile

Well-being

Comparison of WHO–5 well–being mean scores in nurses by country with other healthcare professionals in the survey

The scale ranges from 0 to 100, with a score above 50 being perceived as good wellbeing.

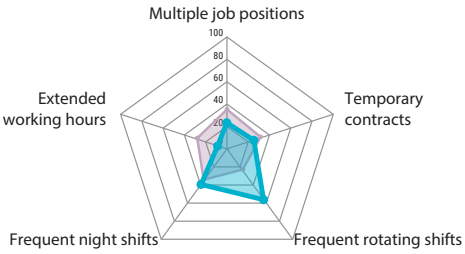
Proportion of responses below 1% in Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland and Bulgaria.



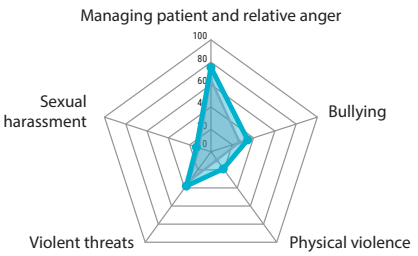
Working conditions

Risk factors

Working hours and contracts

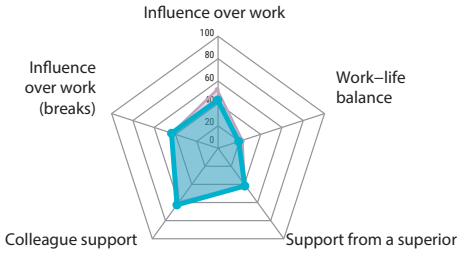


Violence

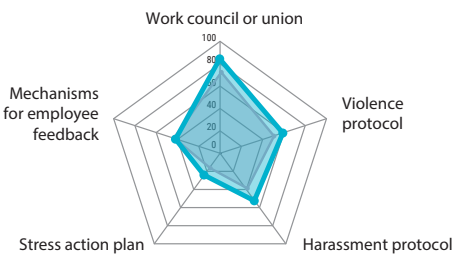


Protective factors

Social support and control

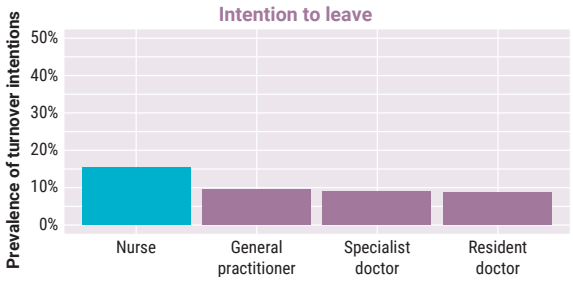


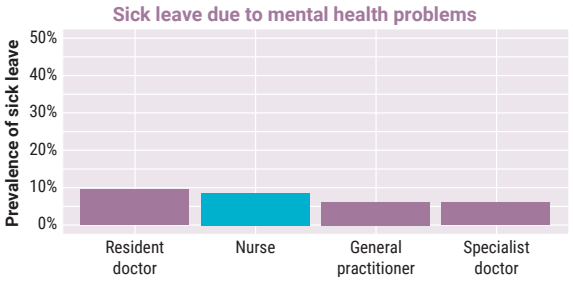
Workplace support structures



Nurses — Doctors

Sick leave and intention to leave





Reported intention to leave profession **15.5%**

Have been on sick leave due to mental health problems **8.6%**

General practitioner
Professional profile

Sample characteristics

Number of female respondents

5 242 68.9%

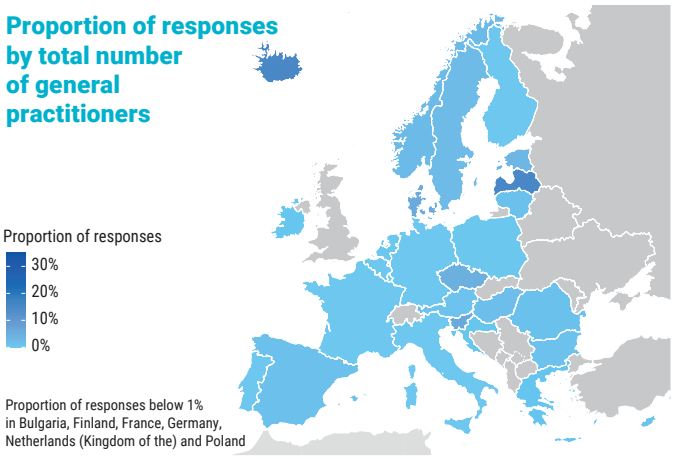
Number of male respondents

2 362 31.1%

Number of respondents aged 55+

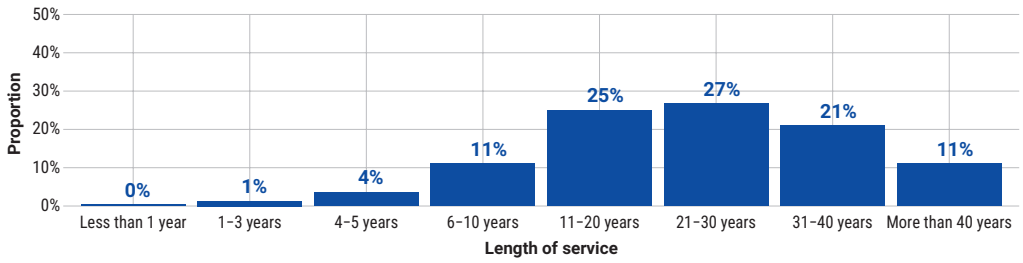
3 117 40.9%

Proportion of responses by total number of general practitioners



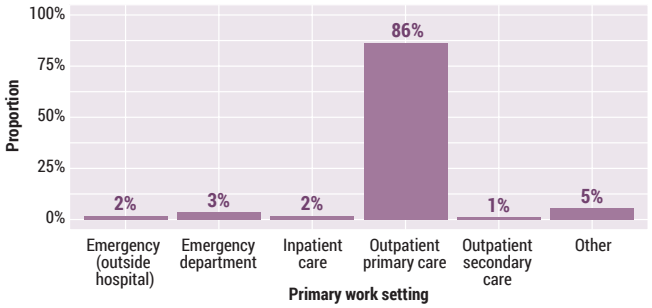
Proportion of responses below 1% in Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland

Length of service

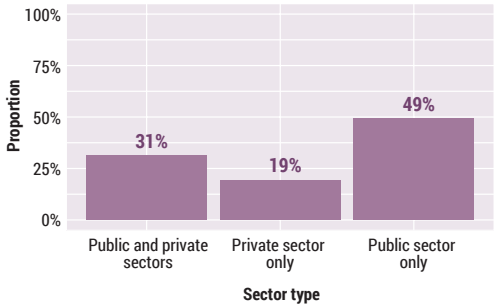


Setting and sector

Primary work setting distribution



Health sector distribution



Prevalence of mental health conditions

	Depression	Anxiety	Alcohol dependence	Passive suicidal thoughts
Female	28.4%	25.9%	2.8%	12.9%
Male	20.4%	17.7%	5.7%	13.0%
Total	26.0%	23.4%	3.7%	13.0%

Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

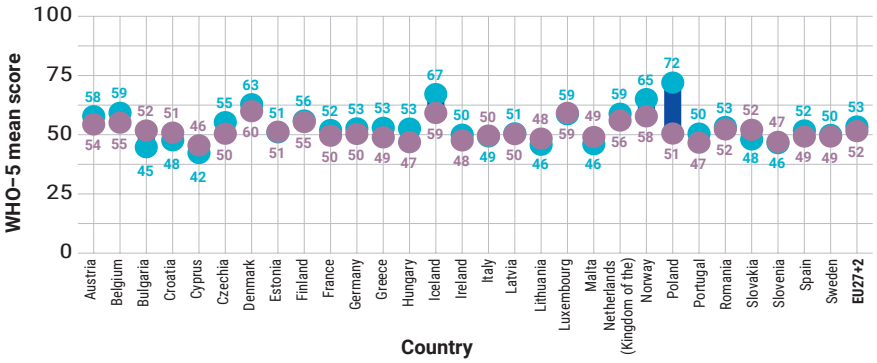
General practitioner
Professional profile

Well-being

Comparison of WHO–5 well–being mean scores in general practitioners by country with other healthcare professionals in the survey

The scale ranges from 0 to 100, with a score above 50 being perceived as good wellbeing.

Proportion of responses below 1% in Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland

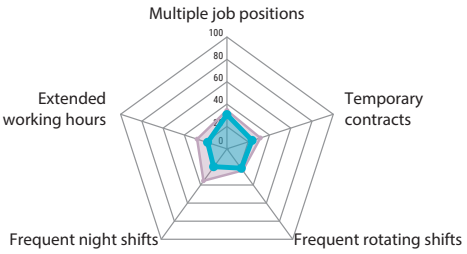


General practitioner Other professionals

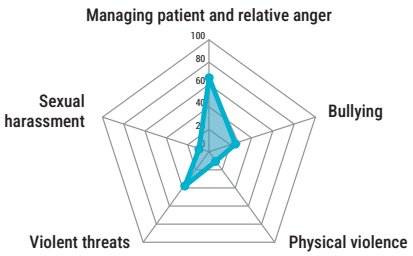
Working conditions

Risk factors

Working hours and contracts

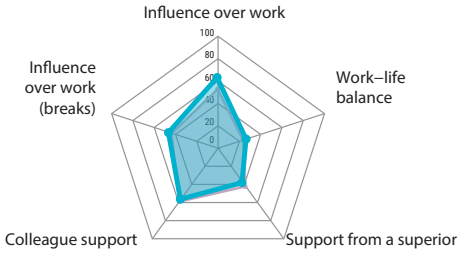


Violence

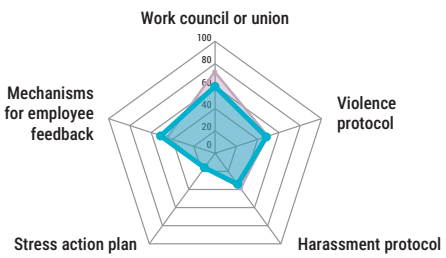


Protective factors

Social support and control

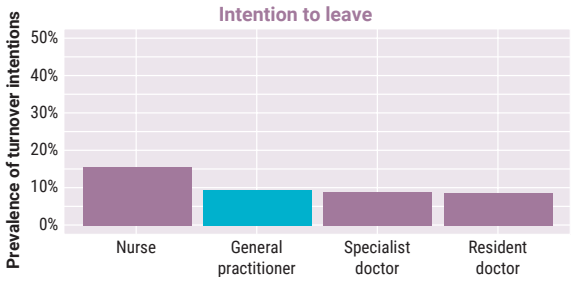


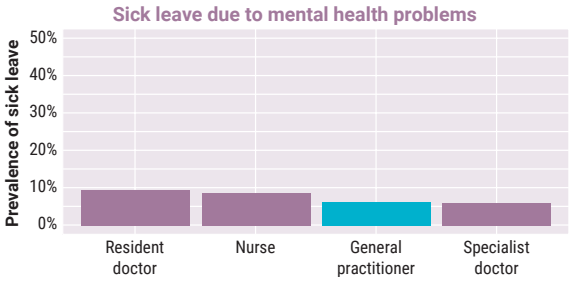
Workplace support structures



General Practitioners Doctors

Sick leave and intention to leave





Reported intention to leave profession **9.4%**

Have been on sick leave due to mental health problems **6.3%**

Resident doctor
Professional profile

Sample characteristics

Number of female respondents

5 235 72.4%

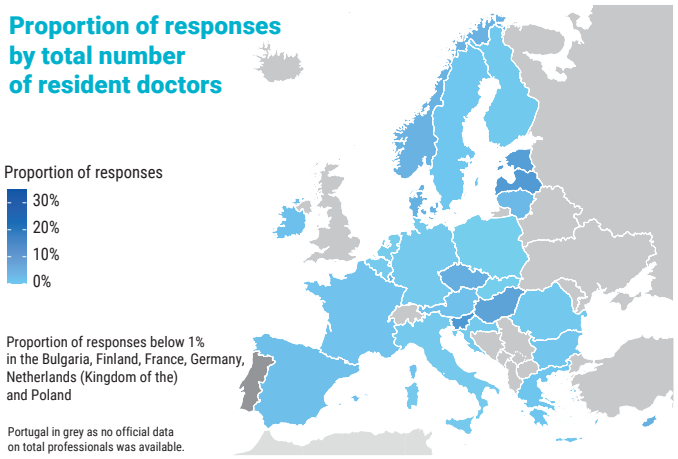
Number of male respondents

1995 27.6%

Number of respondents aged 55+

146 2.0%

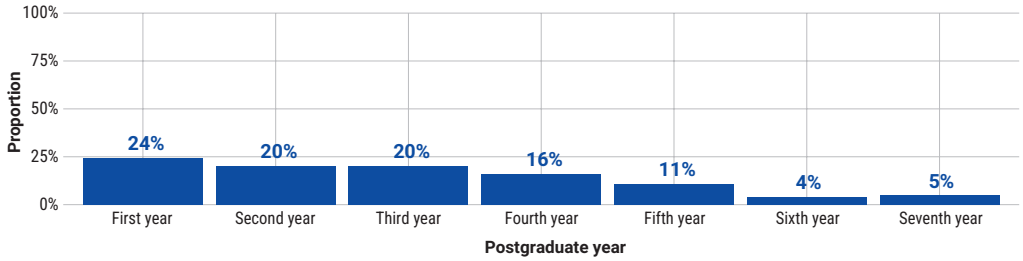
Proportion of responses by total number of resident doctors



Proportion of responses below 1% in the Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland

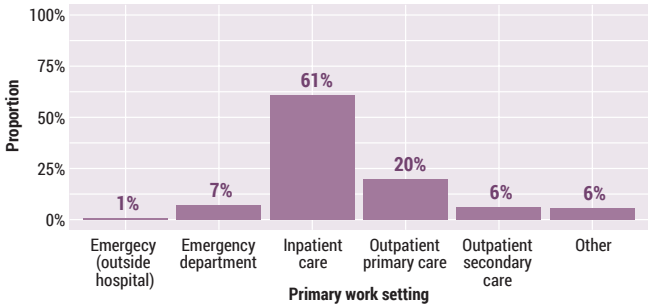
Portugal in grey as no official data on total professionals was available.

Medical residency year

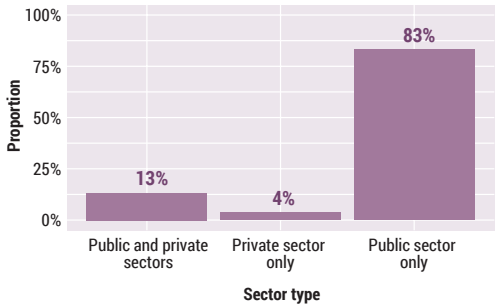


Setting and sector

Primary work setting distribution



Health sector distribution



Prevalence of mental health conditions

	Depression	Anxiety	Alcohol dependence	Passive suicidal thoughts
Female	39.0%	34.8%	3.3%	16.7%
Male	33.5%	29.4%	6.7%	19.6%
Total	37.6%	33.3%	4.3%	17.6%

Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

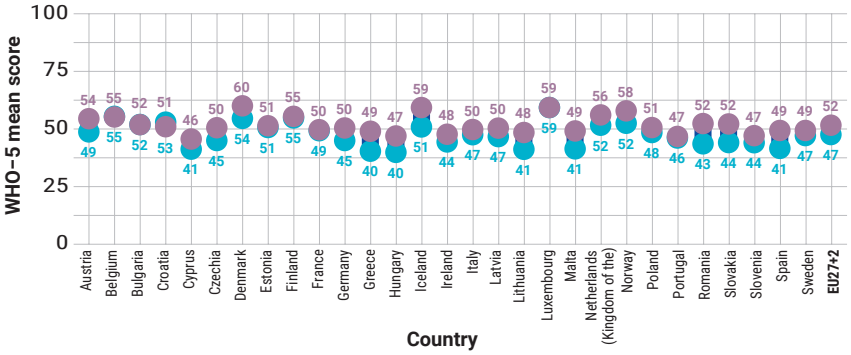
Resident doctor
Professional profile

Well-being

Comparison of WHO–5 well–being mean scores in resident doctors by country with other healthcare professionals in the survey

The scale ranges from 0 to 100, with a score above 50 being perceived as good wellbeing.

Proportion of responses below 1% in Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland

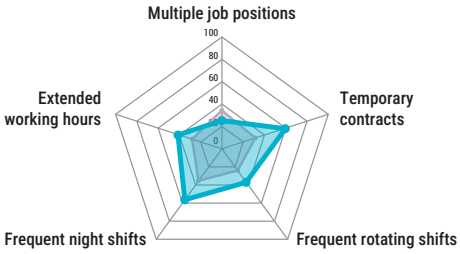


Resident doctor Other professionals

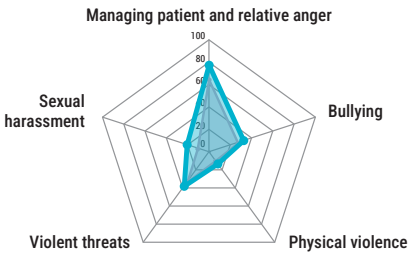
Working conditions

Risk factors

Working hours and contracts

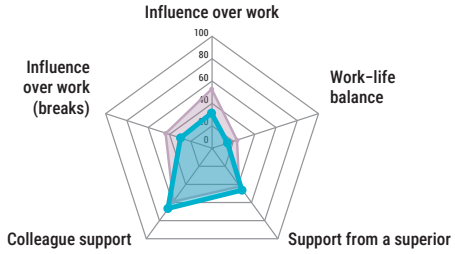


Violence

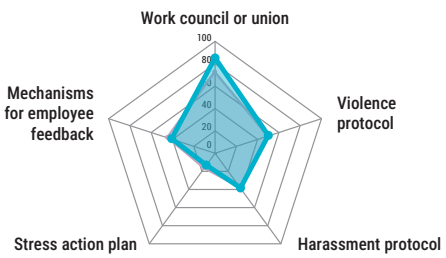


Protective factors

Social support and control

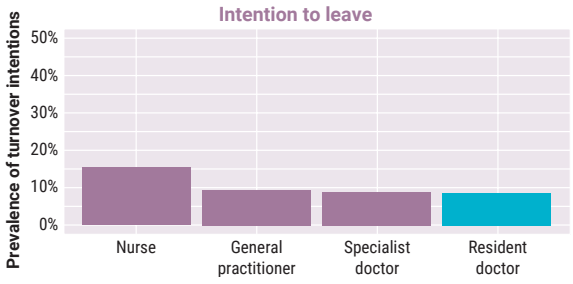


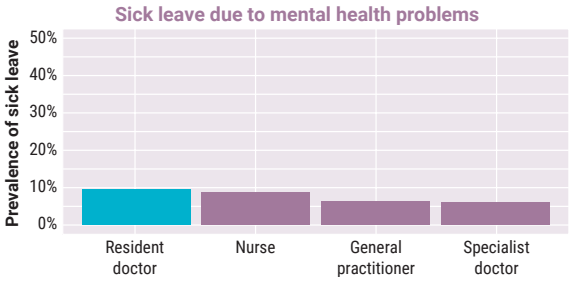
Workplace support structures



Resident doctors Doctors

Sick leave and intention to leave





Reported intention to leave profession **8.7%**

Have been on sick leave due to mental health problems **9.6%**

Specialist doctor
Professional profile

Sample characteristics

Number of female respondents

14 586 65.1%

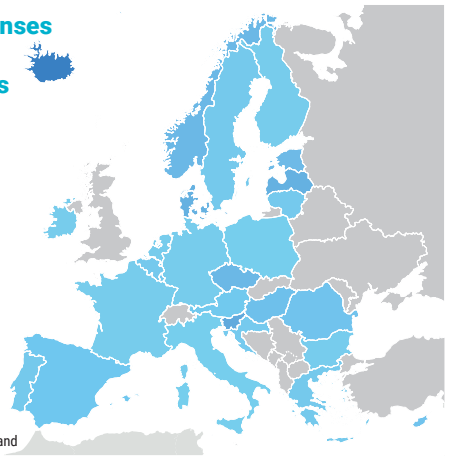
Number of male respondents

7 833 34.9%

Number of respondents aged 55+

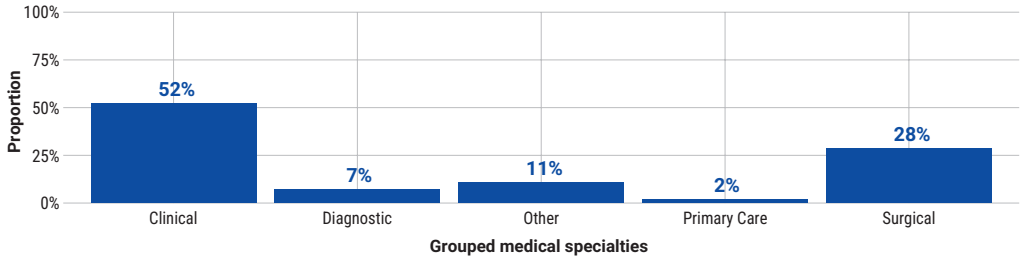
8 162 36.3%

Proportion of responses by total number of specialist doctors



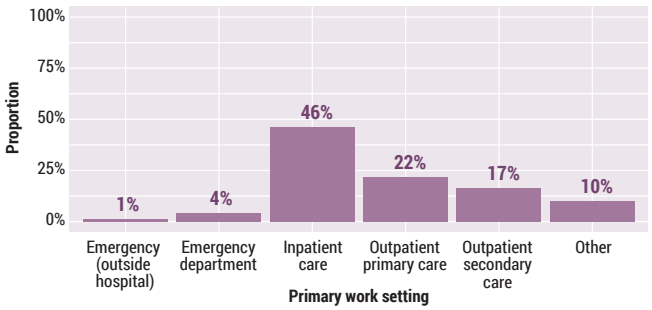
Proportion of responses below 1% in Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland

Medical specialty categories

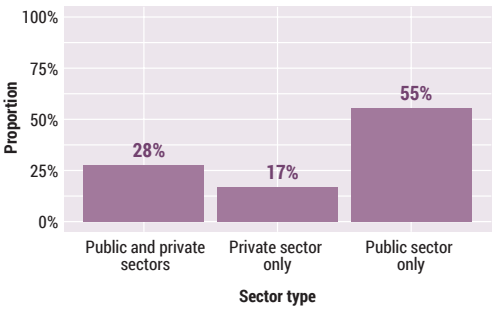


Setting and sector

Primary work setting distribution



Health sector distribution



Prevalence of mental health conditions

	Depression	Anxiety	Alcohol dependence	Passive suicidal thoughts
Female	27.9%	23.2%	2.9%	12.9%
Male	20.9%	16.6%	6.3%	13.1%
Total	25.5%	20.9%	4.1%	13.0%

Note: Depression= Probable major depressive disorder as estimated using the PHQ-9; Anxiety= Probable generalized anxiety disorder as estimated using the GAD-7; Alcohol dependence= probable alcohol dependence as estimated using the CAGE screening tool; Passive suicidal thoughts= Presence of thoughts that one would be better off dead or of wanting to harm oneself, measured using the ninth item of the PHQ-9. For detailed information, see Annex 1: Methodology.

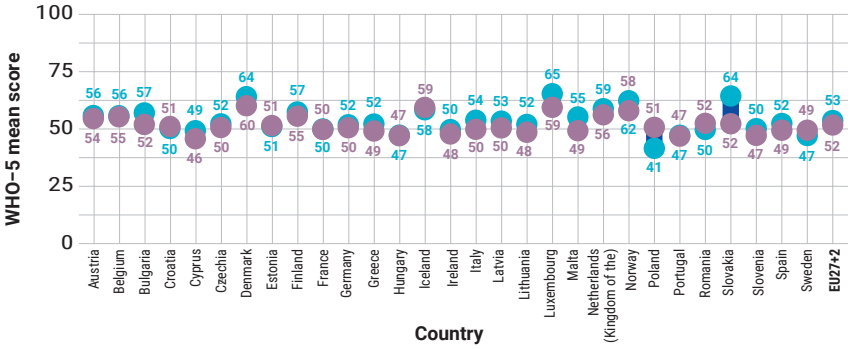
Specialist doctor
Professional profile

Well-being

Comparison of WHO–5 well–being mean scores in specialist doctors by country with other healthcare professionals in the survey

The scale ranges from 0 to 100, with a score above 50 being perceived as good wellbeing.

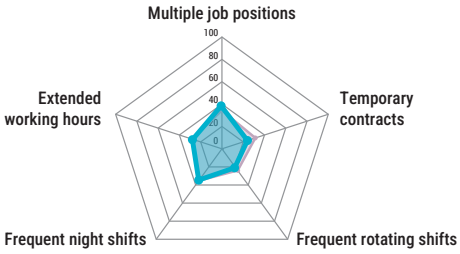
Proportion of responses below 1% in Bulgaria, Finland, France, Germany, Netherlands (Kingdom of the) and Poland



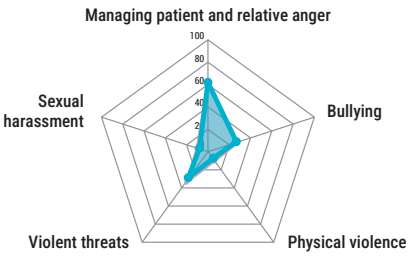
Working conditions

Risk factors

Working hours and contracts

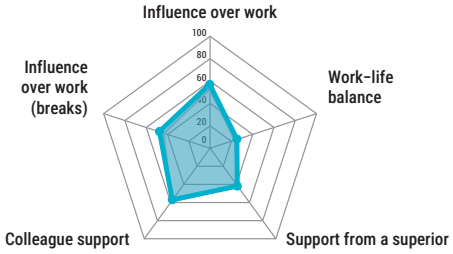


Violence

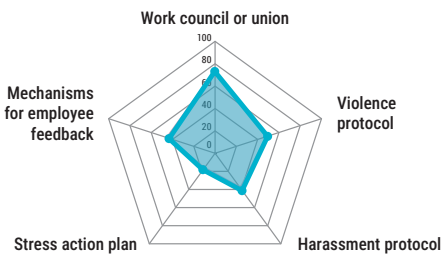


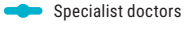
Protective factors

Social support and control

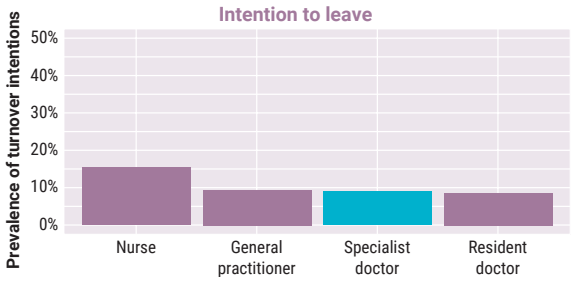


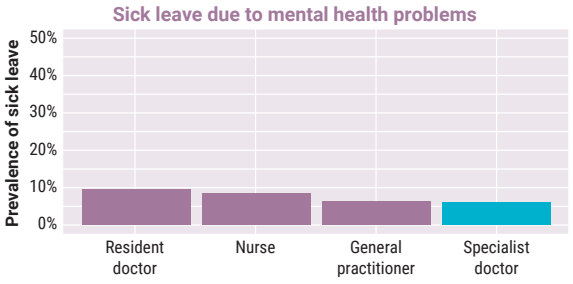
Workplace support structures





Sick leave and intention to leave





Reported intention to leave profession **9.0%**

Have been on sick leave due to mental health problems **6.1%**

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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World Health Organization
Regional Office for Europe

UN City, Marmorvej 51,
DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: eurocontact@who.int
Website: www.who.int/europe

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